

Pediatric Health Summary

Patient's Name: _____ Date of Birth: _____
Mother's Name _____ Date of Birth: _____
Pediatrician's Name: _____ Today's Date: _____

Check all current or past medical conditions. If none, check none.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Skin Ulcers/Keloids |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Current Pregnancy | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Unusual Moles |
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Thyroid Disease | type: _____ |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Depression Disorder | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Eczema/Psoriasis | type: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Hay Fever/Hives | <input type="checkbox"/> Other (print below) |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Angina/Chest Pain | _____ |
| <input type="checkbox"/> Bacterial Meningitis | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Syndrome |
| | | | type: _____ |

Does the patient need to take antibiotics prior to surgery or dental procedures? Y N

Was there anything unusual during the pregnancy or birth of the child? Y N

If yes, explain. _____

Was the child born prematurely? Y N If yes, at how many weeks? _____

List all past surgeries. _____

List all drug allergies. _____

Have any close relatives had any of the following?

- | | | | |
|-----------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> NO | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing loss at an early age | <input type="checkbox"/> Skin cancer other than melanoma |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Deafness | <input type="checkbox"/> Head or neck cancer | <input type="checkbox"/> Unusual mole |

Who does the patient live with? _____

Does the patient attend daycare? Y N

What school district does the patient attend or live in? _____

Is the patient exposed to cigarette smoke or does the patient smoke? Y N

How many siblings does the patient have? _____

What is the patient's primary language? _____ Secondary? _____

Developmental history: (Please check)

- | | | | | |
|---------------------------------|---------------------------------------|--|---|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Speech delay | <input type="checkbox"/> Hearing delay | <input type="checkbox"/> Behavioral delay | <input type="checkbox"/> Coordination delay |
|---------------------------------|---------------------------------------|--|---|---|

You MUST complete the next side.

Check all that CURRENTLY apply.

Are you currently feeling in good health? Y N

General:

- Fevers
- Chills
- Night sweats
- Weight loss
- Weight gain

Cardiac:

- Arrhythmia
- Chest pain
- Fainting spells
- Ulcers of the feet/ankles
- Swelling of the feet/ankles

ENT:

- Hearing loss
- Ear ringing
- Dizziness
- Voice changes
- Nasal obstruction
- Sores in the mouth

Neurological:

- Headache
- Seizures
- Weakness

Respiratory:

- Cough
- Shortness of breath
- Coughing up blood
- Wheezing

GU:

- Difficulty urinating
- Pregnancy
- Breast feeding
- Considering pregnancy

GI:

- Heartburn
- GERD
- Bloody stool
- Difficulty swallowing

Eyes:

- Double vision
- Blurred vision
- Redness
- Swelling

Endocrine:

- Increased thirst
- Increased sweating

Musculoskeletal:

- Joint pain
- Joint swelling
- Limited joint movement

Hematologic/Lymphatic:

- Painful glands
- Enlarged glands
- Easy bruising

Allergy:

- Itchy eyes
- Sneezing
- Hives

Psychiatric:

- Depression
- Anxiety
- Poor sleep

Skin:

- New mole
- Changing mole
- Non-healing sore
(greater than 2 months)

List all CURRENT medications. See attached list.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient or legal guardian signature: _____ Date: _____

<p>For office use only: (You must have at least 3 of the following!)</p> <p>BP: _____ / _____ Temp: _____ ° Height: _____ " Weight: _____ lbs Pulse: _____</p> <p>Entered into PXpert on: _____ Entered by: _____</p>
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