Advance Pediatrics PLLC
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# Child's Current and Past History

**Child's Name: _____ Nickname: _____**

**DOB _____ M □ F □**

| Question | Yes | No | Explain |
|---|---|---|---|
| 1. Child currently on any medication? | | | |
| 2. Child have any serious or chronic illness? | | | |
| 3. Child had any surgeries? | | | |
| 4. Child ever been hospitalized? | | | |
| 5. Child allergic to any medications? | | | |
| 6. Child ever reacted to immunizations? | | | |
| 7. Child has or ever had Asthma, Recurrent cough, bronchitis or pneumonia? | | | |
| 8. Nasal allergies or eczema? | | | |
| 9. Frequent ear infections or sore throat? | | | |
| 10. Problems with ears or hearing? | | | |
| 11. Problems with eyes, vision or teeth? | | | |
| 12. Frequent headaches or neurologic problem? | | | |
| 13. Frequent abdominal pain? | | | |
| 14. Constipation requiring doctor visits? | | | |
| 15. Bladder/Kidney problems or bedwetting? | | | |
| 16. Any heart problems/murmur? | | | |
| 17. Anemia or bleeding problems? | | | |
| 18. Thyroid or other gland problems? | | | |
| 19. Diabetes? | | | |
| 20. ADD/ADHD? | | | |
| 21. Mental health issues? | | | |
| 22. Use of drugs or alcohol? | | | |
| 23. Child care? | | | |
| 24. Smokers in household? | | | |
| 25. Pets in House? | | | |