



PEDIATRIC MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE PRINT

Name of Child _____ Birth Date ____/____/____ Today's Date ____/____/____

Parent's Names _____ Child's School _____ Grade _____

Father's Occupation _____ Mother's Occupation _____ Marital Status _____

Referring Physician _____ Pediatrician/Family Physician _____

Please list all current medicines that child takes:

Medical problems, hospitalizations: yes no *If yes, please list:*

Allergies to any medicines: yes no *If yes, please list:*

Learning problems, ADD, ADHD? yes no *If yes, please describe:*

Birth weight: _____ lbs _____ ozs

Premature? no yes _____ weeks of pregnancy

Child first crawled: _____ months

Child first walked: _____ months

Child spoke first word: _____ months

Family history of crossed eyes/lazy eye? yes no *If yes, please describe:*

Family history of glasses? yes no *If yes, please describe:*

Has child worn glasses? yes no

Has child worn an eye patch? yes no

Has child had eye surgery? yes no *List with dates:*

Has child had other surgery? yes no *List with dates:*

DOES YOUR CHILD **CURRENTLY** HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

Circle Y or N	If yes, please describe
Y N Ears/throat: i.e. hearing loss	
Y N Heart: i.e. murmur	
Y N Lungs: i.e. wheezing	
Y N Digestive: i.e. diarrhea	
Y N Muscles/joints: i.e. low muscle tone or weakness	
Y N Skin: i.e. rash	
Y N Neurologic: i.e. seizures	
Y N Hormones: i.e. low thyroid	
Y N Psychiatric: i.e. depression	
Y N Blood/lymph: i.e. leukemia	
Y N General: i.e. delayed growth	