

# PEDIATRIC FORM

To be used for children 12 years of age or under, and in conjunction with all other forms.

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: F \_\_\_\_\_ M \_\_\_\_\_

*For Office use only:*

## **SYMPTOMS**

**(mark C for current and P for past symptoms)**

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
| _____ Hives             | _____ Talks in sleep     | _____ Vomiting spells    |
| _____ Eczema            | _____ Bruises easily     | _____ Bleeding gums      |
| _____ Chronic rash      | _____ Dizzy spells       | _____ Jaundice           |
| _____ Hair loss         | _____ Cough              | _____ Nosebleeds         |
| _____ Excessive fatigue | _____ Wheezing           | _____ Nervous            |
| _____ Bed wetting       | _____ Anemia             | _____ Sensitive to light |
| _____ Sore throats      | _____ High fevers        | _____ Bad breath         |
| _____ Frequent colds    | _____ Blood in urine     | _____ Body Odour         |
| _____ Canker sores      | _____ Stomach aches      | _____ Motion sickness    |
| _____ Burning urination | _____ Constipation       | _____ Freq. Headaches    |
| _____ Cries easily      | _____ Diarrhea           | _____ Joint pains        |
| _____ Sleep problems    | _____ Gas                | _____ Flat feet          |
| _____ Nightmares        | _____ Change in appetite | _____ Hearing loss       |
| _____ Night sweats      | _____ No appetite        | _____ Heart murmur       |
| _____ Walks in sleep    |                          |                          |

## **MEDICAL HISTORY**

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent colds  | <input type="checkbox"/> Measles       |
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Mumps         |
| <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> Rubella       |
| <input type="checkbox"/> Tonsillitis     | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Pneumonia     |
| <input type="checkbox"/> Chicken Pox     |  |

Other (please list)

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