Boston Children's Health Physicians
Until every child is well™

formerly CWPW

Please answer all the questions on the following three pages to the best of your ability.

Child's name: ______________________________

Describe in your own words the problem(s) which have caused you to see the physician today.______________________________

____

____

____

Has your child ever been hospitalized or seen in the emergency department for this/ these problem(s)? (If yes, state when.)______________________________

____

____

Do these symptoms ever awaken your child at night? If yes, how often?

____

Please list the names of other physicians you may have seen for this problem.

__________ __________ __________

__________ __________ __________

PAST HISTORY

Birth History

Born where?______________________________

Length of pregnancy______________________________

Birth Weight______________________________

Any complications with delivery ? ______________________________

How old when discharged from nursery______________________________

Growth and Development (Normal? Delayed?)______________________________

FEEDING HISTORY

Breast__________ Formula__________ Formula changes?______________

Troubles with feeding (vomit, gas, diarrhea, etc) ?

Immunizations and dates

DPT______________

Measles______________

Mumps______________

Rubella______________

Hepatitis B______________

Other ______________

Polio______________

Tetanus booster______________

Influenza______________

HIB______________

Chickenpox______________

any other adverse reaction?

ILLNESSES

Has your child ever been **diagnosed** with any of the following (Please check **YES** or **NO**)

	YES	NO
Mumps	______	______
Chicken Pox.........................	______	______
Measles.............................	______	______
German Measles.................	______	______
Croup................................	______	______
Asthma..............................	______	______
Hay fever/ Allergic Rhinitis.......	______	______

Boston Children's Health Physicians
Until every child is well™
formerly CWPW

	YES	NO
Sinus Problems................	______	______
Ear infections/ otitis media...	______	______
Bronchitis......................	______	______
Pneumonia....................	______	______
Tuberculosis..................	______	______
Eczema/ Dermatitis...........	______	______
Arthritis/ Joint aches..........	______	______
Other______		______

Any Surgeries______________________________

Any blood transfusions______________________________

Any Hospitalizations______________________________

FAMILY HISTORY: PLEASE CHECK ALL THAT APPLY TO MEMBERS OF PATIENT'S FAMILY.

	MOTHER	FATHER	SIBLINGS	OTHER
Hay Fever...............	______	______	______	______
Asthma..................	______	______	______	______
Sinus problems..........	______	______	______	______
Nasal Polyps............	______	______	______	______
Hives/Swelling..........	______	______	______	______
Eczema/Dermatitis.....	______	______	______	______
Drug allergy.............	______	______	______	______
Stinging Insect Allergy.	______	______	______	______
Emphysema/ COPD..	______	______	______	______
Chronic Bronchitis...	______	______	______	______
High Blood Pressure	______	______	______	______
Heart Disease.........	______	______	______	______
Diabetes...............	______	______	______	______
Thyroid disorder......	______	______	______	______
Cancer.................	______	______	______	______
Other..................	______	______	______	______

REVIEW OF SYSTEMS:

Please circle any of the following symptoms which the child is currently experiencing or which have caused serious problems in the past.

General:	Fever, night sweats, weight changes, fatigue, loss of appetite
Eyes:	Itching, tearing, dry eyes, redness, swelling, discharge
Ears:	ear fullness, popping, itching, loss of hearing, infections
Nose:	sneezing, itching, runny nose, stuffy/ congested, yellow/ green discharge
Throat:	sore throat, post nasal drip, itchy palate
Lymph glands:	glandular swelling, glandular tenderness
Chest:	cough, nighttime cough, wheezing, frequent respiratory infections, Shortness of breath
Intestinal Tract:	nausea, vomiting, indigestion, trouble swallowing, stomach pain, Constipation, diarrhea, excessive gas.

Boston Children's Health Physicians
Until every child is well™
formerly CWPW

Urinary: trouble with urination, frequent urination, burning urinary infections, Other________

Rheumatologic: joint stiffness, joint swelling, joint pain

Skin: rash, hives, welts, itching, eczema, hair loss

Neurologic: Black out, severe headache, epilepsy (seizures), inability to concentrate, trouble sleeping

Other:

ENVIRONMENTAL HISTORY

Please check or complete the answers to describe your home

Type of homes: House______ Apartment______ Other_________
Location: City_________ Suburban_________ County___________
Near your home is there a : Barn_____ Stream_________ Prairie________ Factory_____ Other_______
Approximate age of home_____years Years of occupancy________-
Obvious mold mildew? YES/ NO Lots of dust? YES/NO Roaches? YES/NO
Heating System: Forced air _____ Radiator______ Baseboard_____ Other_____
Air conditioning: Central_________ Window Unit_____ Fans_____ In Summer windows are: OPEN_____Closed_______
How often you change the air filter___________
Floor covering: Carpet_____ Area rug_____ Wood_____ Other_________
Is there a basement or crawl space? YES_____ NO______ Has there been any flooding? YES______ NO_______

BEDROOM

Floor covering: Carpet____ Area rug_____ Wood_____ Other_____

Bed mattress: Conventional _________ Futon________ Water______ Age in years?____
Dust mite cover? YES____ NO______
Comforter: Cotton/Synthetic_______ Feather/Down_____ Wool_____ Age in years________

HOUSEHOLD PETS: Cat______ Dog______ Bird____ Other______
Do they go into the bedroom? YES_____ NO______

SMOKERS IN HOME: **NO** **YES (who?)**

School History:
How many days of school (day care) missed per year due to illness?___________
Does your child have symptoms during gym class or other activity?___________
Does your child take medications at school (day care)?___________________
Is your child exposed to any of the following at school (day care)? (circle)
Animal (rabbits, mice, etc) Dusts Chemicals Smoking Other___________