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.......	______	______

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	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.

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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__________