MURAT BANKACI, M.D., P.C.

PEDIATRIC HEALTH HISTORY FORM

Name________________________ Date of Birth________________ Date ______________

MR # ____________________ Pharmacy ______________________________________

CHIEF COMPLAINT

What is your child being seen for today? ________________________________

How long has your child had this problem? ________________________________

What medications have been used to treat this problem?________________________

PAST MEDICAL HISTORY

Does your child have any sensitivity or allergic reactions to any medications? Yes No

If yes, please list the name of each and the type of reaction: ____________________

Does your child have any allergy to latex? Yes No

Does your child have easy bruising, prolonged bleeding of hemophilia? Yes No

Please list any surgeries or hospitalizations your child has had:

Surgery/Reason for Hospitalization	*Date*	*Complications*

Please list any major illnesses and/or other injuries:____________________________

MEDICATIONS

Current Medications	*Dose*	*Frequency*

FAMILY HISTORY Please check any medical problems that run in your child's family (grandparents, parents and siblings)

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Asthma
- ☐ Problems with Anesthesia
- ☐ Allergy/Hay Fever
- ☐ Hearing Loss
- ☐ Bleeding Problems
- ☐ Ear Infections

Please Specify (who) ______________________________ Other: ______________

SOCIAL HISTORY

Are all immunizations up to date? Yes No

Is the child exposed to tobacco smoke in the home, car or other indoors? Yes No

Is the child in daycare? Yes No If attending school, what grade?____________

Are there any pets at home? Yes No If yes, please list______________________

(Continued on back)

RECENTLY HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS:

PLEASE RESPOND TO ALL QUESTIONS

Review of Systems

Ears

yes no trouble hearing

yes no hearing loss

yes no ringing in ears

yes no ear pain

yes no ear infection

if yes, how many in 6 months ___

how many in 12 months ___

yes no drainage from ears

yes no balance problems (dizziness, unsteadiness, falling)

Nose

yes no stuffy nose

yes no colored or thick nasal discharge

yes no frequent nose bleeds

Mouth and Throat

yes no frequent sore throats

if yes, how many in 6 months ___

how many in 12 months ___

yes no bad breath

yes no noisy breathing/snoring

yes no gasping and/or choking during sleep

yes no apnea (stops breathing during sleep)

yes no bed wetting

Cardiovascular

yes no heart trouble

Respiratory

yes no cough

yes no asthma or wheezing

yes no shortness of breath

yes no croup

Hematologic

yes no easy bruising or bleeding

yes no persistant swollen glands or lymph nodes

Allergic

yes no hay fever or dust/mold allergy

yes no food sensitivity or intolerance

Gastrointestinal

yes no heartburn or acid reflux

yes no nausea or vomiting

yes no diarrhea

yes no ulcers

yes no frequent use of antacids

Integumentary

yes no skin disease

Neurological

yes no seizures

yes no speech difficulties

yes no frequent headaches or migraines

Endocrine

yes no thyroid trouble

yes no diabetes

Immunologic

yes no allergy tests

Recent x-ray, CT scan, MRI or other test

yes no If yes, which test, when, where and for what reason ____________

____

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Signature: ______________________ Relationship: ____________

Date: ____________