Children's Hospital of Pittsburgh | of UPMC

MEDICAL HISTORY

Patient's Name _____

Date of Birth _____

Has your child had any of the following conditions or medical history in the past?
If you answer "yes" to any, please provide the patient's age at the time.

	No	Yes	Comment
Seizures			
Thyroid disease			
Diabetes			
Heart disease			
Heart murmurs			
High Blood Pressure			
Strokes			
Asthma			
Reactive Airway Disease			
Pneumonia			
Reflux disease of stomach			
Liver disease, such as hepatitis			
Kidney disease			
Bone, joint disease or muscular problems			
Need for oxygen at home?			
Tracheomalacia?			
Neck masses, hemangiomas or tumors of the face/mouth or neck?			
Heavy snoring or sleep apnea?			
Has your child had any of the following symptoms within the past week?			
Vomiting			
Fever			
Chills			
Ear pain, ache or pulling at ears			
Runny nose			
Nasal congestion			
Sore throat or pain swallowing			
Swollen glands			
Cough			
Difficulty breathing			
Wheezing or whistling			
Chest congestion			
Stomach pain			
Burning or pain with urination			

What is the reason for your child's visit? _____

Has your child had any surgical procedures? _____

Has your child had any procedures that required your child to have medication to sleep? _____

If so, did your child have any reactions or complications? _____

Does your child take any medications? Please list. _____

Does your child have any allergies? _____

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