Kaleidoscope Kids

Initial Patient History

Date: Form completed by:

Patient Name:_____ DOB:_____Male____Female____

Name of Sibling	Age	Name of Sibling	Age

Birth History:

Pregnancy complications, if any:_____

Did mother smoke, use drugs, or alcohol during pregnancy? Yes No

Birth weight_____Length at birth_____ Term Preterm_____

Vaginal delivery C-section Delivery complications if any:_____

Problems with baby after birth, if any: _____

_____

Family History:

Allergies/eczema		Ear infections/tubes	
Asthma		Learning Problems	
High cholesterol		ADHD	
High blood pressure		Depression	
Heart Disease/Stroke		Anxiety	
Sudden Death before 50yr		Drug/Alcohol abuse	
Anemia/Bleeding disorder		Other Mental illness	
Diabetes		Mental Retardation	
Thyroid disorder		Deafness/Hearing loss	
Gastrointestinal disorder		Vision loss	
Kidney disorder		HIV/immunodeficiency	
Cancer		Tuberculosis	
Seizure disorder		Bed wetting	
Hepatitis			

Patient History:

Patient Name:_____**DOB:**_____

Drug allergies? No Yes (medication & reaction)_____

Surgery/Reason for Hospitalization	Date

Current medication	Dosage	Prescribed by

Review of Systems: Does the patient currently have or ever had any of the following:

Chickenpox	
Frequent ear infections	
Problems with ears or hearing	
Nasal allergies	
Problems with eyes or vision	
Asthma, bronchitis, pneumonia	
Any heart problem or murmur	
Anemia or bleeding problem	
Blood transfusion	
Frequent abdominal pain	
Constipation , vomiting, or diarrhea	
Bladder or kidney infection	
Bed-wetting (after 5 yrs old)	
Eczema/recurrent skin problem	
Frequent headaches	
Seizures/ other neurological problems	
Diabetes	
Thyroid or other endocrine system	
ADHD, anxiety, or depression	
Behavior or other problems	
For Girls Only:	
Has she started her menstrual periods?	
Problems with her periods?	