



Developmental-Behavioral Pediatrics Interim Medical History

Date of Last Visit: _____

Please indicate whether your child has any of the following problems currently or since last seen. If yes, describe.

Headaches	NO	YES	_____
Stomachaches	NO	YES	_____
Chest pain	NO	YES	_____
Other Pain	NO	YES	_____
Poor appetite	NO	YES	_____
Breathing Problems	NO	YES	_____
Passing Out/Dizziness	NO	YES	_____
Seizure	NO	YES	_____
Aggressive behavior	NO	YES	_____
Injuring himself or herself	NO	YES	_____
Repetitive Behaviors/Habits	NO	YES	_____
Tics	NO	YES	_____
Worries or Fears	NO	YES	_____
Sleep Problems	NO	YES	_____
Constipation	NO	YES	_____
Wetting pants or bed	NO	YES	_____
Soiling pants or bed	NO	YES	_____

Do you have concerns about your child's safety? NO YES _____

Please list any medications, supplements, or vitamins that your child is taking:

1. _____
2. _____
3. _____

Does your child have allergies to:

Drugs	NO	YES	_____
Foods	NO	YES	_____
Latex	NO	YES	_____
Contact	NO	YES	_____
Contrast give for x-ray studies	NO	YES	_____
Blood products	NO	YES	_____

Are there other concerns or events since the last visit that you think we should know about?
