DOUGLAS C. MC CORKLE, M.D.

PEDIATRIC & ADOLESCENT PATIENT QUESTIONNAIRE

TODAY'S DATE _____ PEDIATRICIAN _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

AGE _____ DATE OF BIRTH _____ / _____ / _____ MALE _____ FEMALE _____ HT: _____ WT: _____

REASON FOR TODAY'S VISIT _____

GENERAL HEALTH HISTORY

IS THERE ANY HISTORY OF THE FOLLOWING?

ASTHMA	_____ YES _____ NO	HEART PROBLEMS	_____YES _____ NO
SEIZURES	_____ YES _____ NO	BLOOD CLOTTING PROBLEMS	_____ YES _____ NO
MOUTH BREATHING	_____ YES _____ NO	SNORING	_____ YES _____ NO
ANESTHESIA PROBLEMS	_____ YES _____ NO	HEARING LOSS	_____ YES _____ NO

OTHER MEDICAL PROBLEMS? _____

_____

IS THE CHILD TAKING ANY MEDICATIONS? _____ YES _____ NO IF YES, PLEASE LIST ALONG WITH DOSAGES

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

MEDICATION _____ DOSE _____

DOES THE CHILD HAVE ANY ALLERGIES? (HAYFEVER, MEDICATIONS, LATEX) _____ YES _____ NO PLEASE LIST.

TYPE OF ALLERGY _____

_____

HAS THE CHILD HAD ANY SURGERIES? _____ YES _____ NO IF YES, PLEASE LIST.

SURGERY _____ DATE _____

SURGERY _____ DATE _____

SURGERY _____ DATE _____

IS THERE A FAMILY HISTORY OF HEARING LOSS? _____ YES _____ NO

ARE THERE ANY DEVELOPMENTAL DELAYS? _____ YES _____ NO

THANK YOU!