

THE WOODLANDS INSTITUTE FOR HEALTH & WELLNESS
MILA MCMANUS, MD

Name: _____

REVIEW OF SYMPTOMS

Lifetime Antibiotic Use:

How many times has your child used antibiotics? _____

Allergy Treatment:

Has your child ever been evaluated by an allergist? _____

Food allergies? _____

Inhalant allergies? _____

Did s/he ever receive allergy shots? _____

Headaches:

Does your child have headaches? _____

How often? _____

What do you give him or her to relieve them? _____

Nose/Eyes:

Does your child have sinus problems? _____

Does s/he snore? _____

Does your child have chronic post-nasal drip? _____ During or after meals? _____

Do s/he have an itchy nose or eyes? _____

Does s/he sneeze often? _____

Ears:

Has your child had many ear infections? _____

How often? _____

Does your child have hearing difficulty? _____

Mouth:

Does your child develop canker sores? _____

How often? _____

Does your child develop fever blisters? _____

How often? _____

Has your child had cavities filled? _____

Throat:

Does your child often complain of a sore throat? _____

Lungs:

Does your child have frequent chest congestion/cough? _____

Asthma:

Does your child have asthma? _____

Seasonally or year round? _____

Has s/he been hospitalized for asthma? _____

If so, did s/he require a ventilator? _____

Food History:

Does your child drink caffeinated beverages? _____ How many per day? _____

Does your child have any adverse reactions to foods?

List food and symptoms:

Foods

Symptoms

Please describe a typical breakfast for your child: _____

Please describe a typical lunch for your child: _____

Please describe a typical dinner for your child: _____

Please describe a typical snack for your child: _____

Heart:

Has your child been diagnosed with a heart murmur? _____

Has your child ever passed out during sports/exercise? _____

Gastrointestinal System:

Does your child ever complain of heartburn? _____

Does your child frequently complain of stomach aches? _____

Has your child ever passed blood from his/her rectum? _____

Does your child have frequent diarrhea? _____

How many times a week does your child have a bowel movement? _____

Are your child's stools hard, or like pellets? _____

Urinary Tract:

Has your child ever had a bladder infection? _____

Does your child wet the bed? _____

Yeast/Skin Fungus:

Has your child suffered with fungal infections of the groin, body, nails, scalp, or feet? _____

Skin:

Does your child have eczema? _____

Location: _____

Other rashes? _____

Do you know the cause of these rashes? _____

Has your child ever had hives? _____

Do you know the cause of the hives? _____

Does your child have dry or itchy skin? _____

Thyroid:

Has your child ever been diagnosed with a thyroid disorder? _____

If so, was it hyper (high) or hypo (low) thyroid? _____

Malaise/Fatigue:

Does your child seem to be tired all the time? _____

Sweating:

Do your child's hands or feet perspire excessively? _____

Hair Condition:

Has your child experienced excessive hair loss? _____

Weight:

Has your child experienced excessive weight gain? _____ How many pounds? _____

Since what year? _____

Neuro/Psych

Has your child been diagnosed with ADD/ADHD? _____

If not, do YOU feel that your child might have ADD/ADHD? _____

Is your child difficult to manage? _____

Does your child have temper tantrums? _____

Does your child have any tics? _____

Please describe any behaviors that you are concerned about: _____

Has your child been diagnosed with depression? _____
 If not, do you feel that s/he is depressed? _____
 Has s/he taken anti-depressants? _____
 Which one(s)? _____
 Between what ages? _____ and _____
 Has your child been diagnosed with an anxiety disorder? _____
 Has your child reached normal developmental milestones? _____
 If not, please explain: _____
 To your knowledge, has your child suffered from any physical, verbal, or sexual abuse? _____

Sleep:

Does your child have trouble sleeping? _____
 Does s/he have night mares or night terrors? _____

Current Medications:

Does your child take any medications? (Include prescription, over-the-counter, vitamins, supps)

Please list the medication, strength, times/day taken and number of years taken:

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

Past Medical History:

Yes/No	Illnesses	Year	Type:
_____	Cancer	_____	_____
_____	Diabetes	_____	
_____	Hepatitis	_____	
_____	Irritable Bowel Syndrome	_____	
_____	Kidney Disease	_____	
_____	Mitral Valve Prolapse	_____	
_____	Mononucleosis	_____	
_____	Oral Yeast/Mouth Infection	_____	
_____	Pneumonia	_____	
_____	Seizures	_____	
_____	Sexually Transmitted Disease	_____	Type: _____
_____	Chicken Pox	_____	
_____	Measles	_____	
_____	Airborne allergies	_____	
_____	Other	_____	Type: _____

Immunizations:

Has your child been immunized against the following diseases?

_____	MMR	_____	DPT	_____	Polio
_____	Pneumococcal	_____	Hep A	_____	
_____	Chicken Pox	_____	Hep B	_____	

Drug Allergies:

(Please list all drug allergies, and what the reaction is to each medication)

- 1 _____ 4 _____
- 2 _____ 5 _____
- 3 _____ 6 _____

Surgical Procedures:

List any surgeries your child has had:

- | | Year(s) |
|---------|---------|
| 1 _____ | _____ |
| 2 _____ | _____ |

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Family History:

	<u>Age</u>	<u>Medical Problem(s)</u>
Father:	_____	_____
Mother:	_____	_____
Brothers/sisters:	_____	_____
	_____	_____
	_____	_____
	_____	_____
Other:	_____	_____

Social History:

- How many people live in the home? _____
- Does anyone smoke in the house? _____
- Are there pets at the home? _____
- If so, specify type: _____
- Indoor or outdoor? _____
- Does your child play sports on a regular basis? _____ Type: _____
- How many hours of exercise does your child get each day? _____
- How many hours does your child spend watching TV each day? _____
- How many hours does your child spend at the computer each day? _____
- Does your child have normal quality and quantity of friendships? _____

Chief Complaint:

What are your primary concerns? _____

