Institute of Integrative and Age-Management Medicine

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HEALTH HISTORY AND PHYSICAL EXAMINATION FORM

(This form is for patients younger than 21 years of age)

Please complete the following comprehensive personal data form thoroughly for your child. Completion of this form will take time, but the more detailed information we have, the better we can customize treatment.

Today's Date:_____________________________

PART I. PERSONAL INFORMATION

Last Name First Name Middle Initial

Age Birth Date Height Weight Birth Weight

Home Address City State Zip

Home Telephone Cell Phone Email Address

Parents' Names Work Telephone

School Grade

Sex: Male Female

Patient Name:_________________________________

PART II. MEDICATIONS & IMMUNIZATIONS

Which of the following does your child take more than once a week?

None

Tylenol or Ibuprofen	Growth Hormone
Antacids/Reflux Med	Thyroid Medication
Antihistamines/Allergy Pills	Insulin, Diabetic Pills
Arthritis medication	Laxatives
Aspirin	Stomach/Intestinal Pills
Birth Control Pills	Prednisone, etc.
Blood Pressure Pills	Tranquilizers/Sedatives
Decongestants/Cold Pills	Vitamins
Heart Medication	Med. For ADD or ADHD

List any prescription medications by name, and any herbal remedies your child takes:

Did your child receive the Hepatitis B Vaccine? Yes No

If "yes", number of shots 1 2 3 Year completed

Has your child ever received a Flu shot?

Did your child receive all their recommended immunizations?

Did they have any adverse reactions to, or personality changes after, the immunizations?

Additional Comments:

Patient Name:________________________________

PART III. ALLERGIES

None
Drugs
Specify____
Dusts or Molds
Specify____
Pollens
Specify____
Animal
Specify____
Food
Specify____
Other
Specify____

Has your child ever had allergy testing or allergy shots?

Patient Name:___________________________________

PART IV. SOCIAL HISTORY

Does your child have difficulty in school?
Do they enjoy reading?
Do they likes computers or computer games?
Do they play well with other children?

How would you describe your child's temperament and personality?

Does your child drink soft drinks or Kool-Aid? How much per week?
Does your child drink milk? What kind?
How much water does your child drink per day?
Does your child drink fluoridated tap water or bottled water?
Does your child eat a lot of "junk" food?
Do they eat protein and vegeatables every day?

What sports, recreational, or exercise activities does your child participate in?

Additional Comments:

Patient Name:_________________________________

PART V. MEDICAL HISTORY

Which of the following conditions has your child ever had?
Enter year of diagnosis, of known.

- Head Injury
- Headaches
- Seizures
- Birth Complications
- Strabismus/Amblyopia
- Cataracts/Retinal Disease
- Thyroid Trouble
- Diabetes
- Growth Hormone Deficiency
- Heart Murmur, Heart Surgery
- Autism
- Congenital Anomaly
- Cerebral Palsy
- Developmental Delay
- Chromosomal Anomaly
- Motor Vehicle Accidents Or Severe Injuries
- Positive Skin Test For TB
- Hepatitis/Liver Disease
- Metabolic Disorder
- Urinary Tract/Kidney Problems
- Asthma
- Pneumonia
- Spina Bifida/Tethered Cord
- Arthritis
- Attention Deficit Disorder
- Depression/Anxiety
- Sleep Problems
- Anemia, Or Blood Disorder
- Tumors, Or Cancer
- Hearing Problems
- G.I. Problems/Reflux

Comments:

Other medical/psychiatric disorders. Specify.

Additional Comments:

Patient Name:___________________________________

PART VI. HOSPITALIZATIONS AND SURGERIES

Year Reason

Additional Comments:

Patient Name:________________________________

PART VII. FAMILY HISTORY

Number of brothers/sisters, and their ages:

Which of the following problems have occurred in the family?

Thyroid Disease	Depression/Anxiety
Heart Trouble Or Disease	Autoimmune Disease
Cancer Or Leukemia	ADD/ Or ADHD
Diabetes	Asthma/Allergies
High Blood Pressure	Autism
Kidney Trouble	Genetic Diseases
High Cholesterol	Seizure Disorders
Alzheimer's Disease	

What animals do you have in your home?

Does anyone smoke in the home?

Patient Name:___________________________________

PART VIII. SCHOOL/EDUCATION HISTORY

Briefly describe the activities your child's school environment.

How grade is you child in?
Does your child like to go to school?
Has your child had to miss a lot of school due to illness?

Specify

Does your child receive extra tutoring, etc. or school work?

Patient Name:________________________________

PART IX. REVIEW OF SYSTEMS

Which of the following has your child every experienced or complained of?

General/Constitutional
- Fever >101 °F
- Poor Growth
- Poor Eater
- Generalized Weakness
- Unexplained Weight Loss/Gain
- Excessive Fatigue
- Swollen Glands
- Loss Of Appetite

Genitourinary/Reproductive
- Difficult Or Painful Urination
- Urinary Tract Infections
- Loss Of Bladder Control
- Bedwetting
- Frequent Urination
- Precocious Puberty

(Boys Only)
- Hypogonadism
- Testicular Disorder
- Undescended Testicles
- Puberty

(Girls Only)
- Menarche
- Vaginal Discharge
- Irregular Periods
- Menstrual Cramps
- Puberty
- Birth Control Pills

Heart
- Heart Murmur
- Irregular Heart Beat

Lungs
- Shortness Of Breath
- Pneumonias
- Wheezing
- New Or Change In Cough

Digestive System
- Nausea/Vomiting
- Constipation
- Yellow Jaundice
- Rectal Bleeding
- Diarrhea

Neurological/Psychiatric
- Headaches
- Dizziness
- Passing Out/Fainting
- Numbness Or Tingling
- Tics
- Excessive Anxiety
- Insomnia/Difficulty Sleeping
- Excessive Sadness

Skin/Musculoskeletal
- Back/Neck Pain
- Leg Pain
- Joint Pain
- Moles-Changing
- Rashes
- Acne

Eyes
- Change In Vision
- Itching
- Tearing

Ears, Nose, Throat
- Earaches
- Difficulty Hearing
- Ringing, Buzzing
- Sinus Trouble
- Difficulty Swallowing
- Sneezing/Runny Nose
- Nosebleeds
- Mouth Sores
- Hoarseness
- Snoring

Patient Name________________________

Rank each category (circle one) **1= low,poor 3= average, 5= excellent**

Energy level	1	2	3	4	5
Concentration	1	2	3	4	5
Memory	1	2	3	4	5
Fitness	1	2	3	4	5
Sleep	1	2	3	4	5
Eating habits	1	2	3	4	5

Additional Comments:

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I, ____, have read and understand all materials related to the treatment requested from Peggy H. Fishman, MD & the Institute of Integrative and Age-Management Medicine. Responses and answers to written and spoken questions have been answered truthfully and to the best of my ability. Ample and plentiful time was allotted to answer all questions, inquiries, and explanations regarding treatment to make an informed and intelligent decision. Risks, benefits, alternatives and complications from said treatment have been completely and thoroughly explained.

Fees and payment policies have been discussed completely in their entirety. I understand payment is due at the time that services are rendered. Any and all questions regarding fees and payment policy have been answered fully by the clinic. I agree to comply with the designed treatment plan and follow-up tests on a timely fashion as ordered by Peggy H. Fishman, MD. Failure to perform these studies on a timely basis may affect the benefits and safety of the treatment. Termination from treatment may be an option selected, by Peggy H. Fishman, MD & the Institute of Integrative and Age-Management Medicine, if there is poor patient compliance. Patients are encouraged to comply fully with follow-up exams and diagnostic labs/studies requested for a successful program.

I agree and consent to treatment by the Institute of Integrative and Age-Management Medicine and Peggy H. Fishman, MD (inclusive of Peggy H. Fishman, MD and staff of Peggy H. Fishman, MD).

____
Signature

____
Printed Name

____
Witness Signature Printed Name

____
Date Time