PEDIATRICS QUESTIONNAIRE

HASUHANA KIDS FAMILY CLINIC

For Staff Only

Tempreture ℃
Pulse /min
Blood pressure
／ mmHg
Respiratory Rate ／min
SpO2 %

Name of patient
Address

Phone number

Age years old ／Weight kg
Allergies
☐foods : ☐Medicine :

What is the problem today?
Please check all that apply :
When did it start?

☐Fever :
☐Cough:
☐Runny nose :
☐Diarrhea
☐Constipation:
☐Vomiting:
☐Abdominal pain:
☐Chest pain:
☐Palpitation:
☐Vertigo:
☐Headache:
☐Earache:
☐Rash:
☐Convulsion:
☐Allergy consultation
☐Abnormality in ECG
☐Abnormality in urinalysis
☐Others:

1． Have you ever had a febrile seizure? Yes / No

2． Which form of medicine would you prefer ?

☐Syrup
☐Powder
☐Tablet or Capsule
☐Anything is acceptable

3 .Any previous hospitalizations or operations?

4． Are you currently on any medication?

5． Have any diseases been spreading in your school, nursery or in the family?