



PEDIATRICS

*Dr. Shahzad A. Sheikh, M.D., F.A.A.P.
Pediatric and Adolescent Med*

Name: _____ Date of Birth: _____ Male or Female _____

Please circle all answers

1. - Are you allergic to any medication? Yes / No

If so, please list _____

2. - Are you currently taking any medication? Yes / No

If so, please list _____

3. - Have you had any injuries/surgeries? Yes/No

If so, please list description, dates and place: _____

4. - Smokers inside of the house? Yes/No Outside of the house? Yes/ No

Alcohol Yes/No How often? _____

5. - Patient lives with: Mom Dad Stepparent Grandparents Other

6. - Does patient have problems with the following:

-Behavior/ interaction with peers? Yes/No

- School Performance? Yes/No

Parent's signature: _____

Today's date: _____