Recurrent Fevers Questionnaire

Name__________________________DOB___________ Date____________

CHIEF COMPLAINT: (Please briefly summarize why you are seeing us today.)
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

HISTORY OF PRESENT ILLNESS:
1. When was the first episode of fever / what was the age of your child's first fever?
_____________________________________________________________________________

2. What is the usual temperature range of the fevers (Max/min)?
_____________________________________________________________________________

3. How quickly does the fever rise, and for how many hours/ or days does the fever last?
_____________________________________________________________________________

4. Do you use Tylenol or Ibuprofen to bring down the fever? Y/N. If yes, then what temperature does the Tylenol or Ibuprofen bring it to?
_____________________________________________________________________________

5. What symptoms precede the fever? Can you tell when your child is going to have a fever, if so how? Is your child able to tell when they will have a fever?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

6. What symptoms occur during the fever?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

7. In between the fever episodes, how does your child act and appear to you?
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

8. If you have kept a fever diary, please list the fevers by dates and temperature and main symptoms.
a. Date_________ High Temp_______________
   Symptoms_____________________________________
b. Date_________ High Temp_______________
   Symptoms_____________________________________
c. Date_________ High Temp_______________
   Symptoms_____________________________________
d. Date_________ High Temp_______________
   Symptoms_____________________________________


e. Date ___________ High Temp_______________
Symptoms ___________________________________________

f. Date ___________ High Temp_______________
Symptoms ___________________________________________

* Please list additional dates/ symptoms on the back of this sheet.

9. Any diagnoses of infections during these fevers and were they treated with antibiotics?
Any hospitalizations with the fevers?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

10. Has your child lost weight with the fevers? Y/N Does your child's weight return to normal after the fevers subside?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

11. Has any labwork been done with the fevers, and has anything been abnormal or positive?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

12. Was a TB (PPD) test place on your child's arm? Y/N Was it normal? Y/N

13. What is the ethnic heritage of the:
   a. Mother _______________________________________________
   b. Father _______________________________________________
   c. Any Scandinavian or Mediterranean heritage in the family?
     _______________________________________________________
   d. If yes, then is there a family history of children with recurrent fevers?
     _______________________________________________________

SYSTEM REVIEW: Please circle all that apply
General: Fatigue, decreased playful activity, misses school.
HEENT: Redness or swelling of eyes. Sinus drainage, sore throat, ear pain, headache, swollen lymph nodes.
CV: Chest pain, swelling in lower extremities, heart problems.
Pulmonary: Shortness of breath, cough, wheezing or asthma.
GI: Decreased oral intake, diarrhea, stomach pain, nausea or vomiting. Blood in stool.
GU: Pain with urination, bladder infection, kidney infection, back pain, blood in urine or change in urine.
Joint: Joint pain, swelling in joints, inability to move certain joints.
Neuro: Seizures with or without fever. Change in walking pattern. Change in mentation.
EXT: Swelling or joint problems.
Skin: Rashes with or without fever, Hives.
Psyche: Happy and playful after fevers. Sad or depressed.
Endocrine: Diabetes, Thyroid.
ID: Ear infections, Throat infections, Sinus infections, Lung infections, Skin infections, Bone
infections.

**CURRENT MEDICATIONS**: List all vitamins, herbs and medications, with doses and frequency of doses.
1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
4. ___________________________________________________________
5. ___________________________________________________________
6. ___________________________________________________________
*List additional medications on back of sheet.

**ALLERGIES**: List all reactions to medications.
1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
*List additional reactions on back of sheet.

**EXPOSURES**: Circle all that apply.
1. Has you or your child been exposed to someone with known Tuberculosis? Y/N.
   ____________________________________________________________________
2. Is your child in daycare, school, or group care with other children? Y/N.
   ____________________________________________________________________
3. Has your child consumed milk straight from the cow or unpasteurized milk? Y/N
   ____________________________________________________________________
4. Has your child eaten wild game Y/N.
   ____________________________________________________________________
5. Does your child take alternative medications or herbs?. Y/N.
   ____________________________________________________________________
6. Do you have pets or any animals at home? Y/N Please list
   ____________________________________________________________________
   ____________________________________________________________________
7. Do you live near a farm or any livestock or other farm animals?
   ____________________________________________________________________
8. Has your child had any exposure to rodents, or squirrels?
   ____________________________________________________________________
9. Any recent travel either in the US or outside of the US?
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

**IMMUNIZATIONS**:
1. Are your child’s immunizations up to date?. If not, which immunizations have they received?
   ____________________________________________________________________
   ____________________________________________________________________
2. Has your child received the:
   Chicken Pox (Varicella) vaccine: Y/N
   Influenza Vaccine: Y/N
   Hepatitis A Vaccine: Y/N
Hepatitis B Vaccine: Y/N
Prevnar (Pneumococcal) vaccine: Y/N

PAST MEDICAL HISTORY: Please list hospitalizations and surgeries as well as reasons for taking medications. If pt has had no relevant history leave blank.
1. ________________________________________ Date _____________
2. ________________________________________ Date _____________
3. ________________________________________ Date _____________
4. ________________________________________ Date _____________
5. ________________________________________ Date _____________
6. ________________________________________ Date _____________

FAMILY HISTORY: Please list family history of illness by relative.

Mother __________________________________________________________
Maternal Grandmother ____________________________________________
Maternal Grandfather _____________________________________________
Maternal Relative other _____________________________________________

Father __________________________________________________________
Paternal Grandmother _____________________________________________
Paternal Grandfather _____________________________________________
Paternal Relative other _____________________________________________

Any history of arthritis or fevers? Y/N Any history of cancer? Y/N List above.

SOCIAL HISTORY:
1. Where do you live? _____________________________________________
2. What are the parents' occupations? _______________________________
3. What grade or level is your child in school? _______________________
4. What is your child’s hobbies/ favorite subjects? _______________________
5. Any brothers or sisters at home? ________________________________
   What are their ages? ___________________________________________
   Any of those that have been ill recently?
   __________________________________________________________________
   __________________________________________________________________

Parent's Signature ___________________________________ Date_______

Thank you for completing this form. Please bring this form with you to your visit, we will review it with you at that time.