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.