

**Table 4. Pre-school aged child history form (1-5 years)**

<b>Patient information and consent</b>	
Patient name	
Patient date of birth	
Parent/guardian names	
Legal relationship to child	
General practitioner/pediatrician	
Consent to contact other practitioners	
Consent to care	
Consent to use anonymized data for research	
Date	
<b>Primary complaint</b>	
Description (ask parent/guardian & child)	
Onset	
Course since onset	
Possible causes/contributing factors	
Aggravating factors	
Relieving factors	
Behavioral changes	
Associated symptoms	
Previous episodes and management	
Pre-school attendance, engagement	
Activities affected	
<b>Nutrition</b>	
Diagnosed or suspected allergies/intolerances	
Usual diet and any restrictions	
Growth (weight, height, head circumference)	
<b>Sleep</b>	
Sleep patterns	
Any concerns about sleep	
<b>Activity levels</b>	
Physical activity <i>What, how long, how often</i>	
Sedentary time	
Screen time	

**Table 4. Pre-school aged child history form (1-5 years) continued**

<b>Other medical conditions</b>	
General health	
Diagnosed conditions <i>When diagnosed?</i>	
Suspected conditions	
Medications <i>Prescribed and OTC</i>	
Supplements	
GP or hospital visits/admissions <i>When and why?</i>	
Other healthcare professionals seen	
Surgeries <i>What and why?</i>	
Atopic: <i>Skin, respiratory, gastrointestinal</i>	
Injuries	
Infections	
Vaccinations — normal schedule followed?	
Family medical history <i>Who, what, management, outcome</i>	
<b>Review of systems</b>	
Respiratory <i>Recurrent coughs, mucous, wheeze</i>	
Skin <i>Rash, eczema</i>	
Gastrointestinal <i>Pain, vomiting, wind, stool</i>	
Output <i>Frequency of urination and defecation in 24hrs</i>	
Positional or postural preference <i>Asymmetry of head, trunk, or limbs</i>	
Injuries or falls	
Development <i>Does the child move and interact like other children the same age?</i>	
Other <i>Any other thoughts or concerns not covered?</i>	