In Health Naturopathic Medicine
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PEDIATRIC HEALTH HISTORY

Your Child's health is of the utmost importance to me. Please fill out this form as completely and accurately as you can. If you are unsure of how to answer certain items, just circle the item and I will be happy to discuss it with you. All information is treated confidentially.

Child's Name:_____ D.O.B:_____ Age:_____Gender:_____
Child's School:_____ Grade:_____
Previous Physician:_____ City/State:_____ Phone: ( ) - _____
Reason for visit:_____

Please Provide a list if there is not enough room in the allergies, supplements, and medication boxes. Thank you.

Allergies	
Substances	Reaction

Medications/Supplements	
Medication Name	Dosage

Medical History

Please check if child has ever had any of the following conditions:

☐ Allergies
☐ Asthma
☐ Chicken Pox
☐ Measles (10 days)
☐ Measles Rubella (3 days)
☐ Rheumatic Fever
☐ Pneumonia
☐ Whooping cough
☐ Other:_____

GENERAL
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Headache
☐ Loss of sleep
☐ Mood Swings
☐ Numbness
☐ Tiredness
☐ Weight loss/gain

CARDIOVASCULAR
☐ Breathing Problems
☐ Chest Pain
☐ Irregular Heart Beat

EYES
☐ Crossed or Wandering
☐ Eye Irritation
☐ Headaches
☐ Vision Problems

HEARING
☐ Difficulty Listening
☐ Earaches
☐ Ear Infections
☐ Other:_____

DENTAL
☐ Bleeding Gums
☐ Grinding Teeth
☐ Sensitivity to hot/cold
☐ Thumb Sucking
☐ Last Dental check-up
When:_____
☐ Brush
☐ Floss

GASTRONINTESTINAL
☐ Poor Appetite
☐ Bloody/Dark Stools
☐ Constipation
☐ Diarrhea
☐ Excessive Hunger
☐ Excessive Thirst
☐ Nausea
☐ Rectal Bleeding
☐ Diaper Rash
☐ Parasites:_____
☐ Other:_____

MUSCLE/JOINT/BONE
☐ Broken Bones
☐ Posture Problems
☐ Pain/Weakness/Swelling
Where:_____

NOSE/THROAT/CHEST
☐ Difficulty Breathing
☐ Frequent Colds
☐ Hoarseness
☐ Persistent Cough
☐ Sore/Strep Throat
☐ Tonsil Infections
☐ Wheezing
☐ Difficulty Swallowing
☐ Lung Infection
☐ Hay Fever

SKIN
☐ Bruise Easily
☐ Change in Moles
☐ Hives/Itching
☐ Rash
☐ Scars
☐ Birth Mark
☐ Jaundice

IMMUNIZATIONS
☐ HIB – 3 doses
☐ HEP B – 4 doses
☐ DTaP – 3 to 4 doses
☐ DTP – 3 to 4 doses
☐ Polio – 3 doses
☐ MMR
☐ Chicken Pox
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____

Notes: *Please Bring A copy of your child's immunization record. so that we have a copy on File. Thank you.*

HOSPITALIZATIONS

Date Reason

_____ _____
_____ _____
_____ _____

FAMILY INFORMATION

Mother's age: _____ Mother's state of health: _____
Father's age: _____ Father's state of health: _____
Sibling(s):
☐ M ☐ F Age_____ State of health: _____
☐ M ☐ F Age_____ State of health: _____
☐ M ☐ F Age_____ State of health: _____
☐ M ☐ F Age_____ State of health: _____

FAMILY HISTORY please indicate who in your family has any of the following conditions

☐ Diabetes _____
☐ Cancer _____
☐ Heart Disease _____
☐ Asthma/Hay fever _____
☐ Eczema _____
☐ Other: _____

PREGNANCY/BIRTH INFORMATION

Mother's age at time of child's birth: _____ Father's age at time of child's birth: _____
Pregnancy complications? ☐ Gestational Diabetes ☐ Excessive/Inadequate weight gain ☐ excess vomiting
☐ Bed Rest: how long? _____ ☐ other _____
Mother's habits during pregnancy:
☐ Caffeine use ☐ Adequate Exercise ☐ Smoking ☐ Healthy Diet ☐ Alcohol use ☐ Stress ☐ Illicit Drug use
☐ Illnesses: _____
☐ Medications: _____
weeks gestation at birth: _____ (normal is 39-41; premature is < 36) ☐ Induction ☐ Spontaneous Labor
Place of Birth: ☐ Hospital ☐ Clinic ☐ Home Type of delivery: ☐ Vaginal ☐ C-section ☐ VBAC
Labor/Delivery Complications: ☐ N ☐ Y Describe: _____
Medications Used During Labor: ☐ None ☐ Epidural/Spinal ☐ IV ☐ other: _____
Child's weight at birth: _____lbs _____oz Length: _____ Head Circumference: _____

NUTRITION

Infant: ☐ Breastfed: how long? _____ ☐ Formula: ☐ Cow's milk based ☐ Soy-based ☐ other _____
Food Allergies/Sensitivities, if any: _____
Please indicate whether your child eats the following; indicate the number of times per day/week:
☐ wheat _____ ☐ dairy _____ ☐ Soy _____ ☐ Meat _____
☐ Beans _____ ☐ Eggs _____ ☐ peanuts/peanut butter _____
☐ Fruit _____ ☐ Vegetables _____ ☐ Baked Sweets/Candy _____
Favorite foods: _____
Please indicate which of the following your child drinks and how frequently/how much they drink.
☐ Water: _____ ☐ Fruit Juice: _____
☐ Cow's milk: _____ ☐ Other milk: type_____: _____
☐ Sodas without caffeine: _____ ☐ Sodas with caffeine: _____
☐ Coffee: _____ ☐ Other: _____

ACTIVITIES/SOCIAL HISTORY

Please indicate which of the following activities your child engages in and how much time is spent on each activity:

☐ Reading _____ ☐ Watching TV/Computer Use _____

☐ Outdoor Play_____ ☐ Sports/Exercise _____

Favorite Activities: _____

Does your child exhibit any social behaviors you are concerned about and if so, what are they? (For example: depression, difficulty with attention, possible learning disability, difficulty with peers, shyness, etc.)

_____

_____

_____

_____

_____

_____

OTHER

Are you interested in information on the following:

☐ Vaccination/Immunization

☐ Nutrition

☐ Physical Activity/Exercise/Sports Guidelines

☐ Food Allergy Testing

☐ Other_____

Is there anything else you think I should know? _____

_____

_____

_____

_____

I acknowledge and agree that I have read a copy of the physician's Notice of Privacy Practices and that a copy can be provided upon request. I also to my knowledge have filled out the above form with information that is accurate and complete. I understand that it is my responsibility to inform the physician in charge of my care if I ever have a change in health.

_____initials

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if my child ever has a change in health.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Please print name of Parent or Guardian Relationship to Patient