# *Doctor Barbara's Pediatric Health History Form*

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**CHILD'S NAME:**_____ **DOB**: _____/_____/_____ **AGE:** _____ ☐**M** ☐**F**
**Parent Name:** _____ **Parent Name:**_____
**Parents:** ☐Married/Living Together **Parents:** ☐Separated/Divorced (child primarily lives with)_____
**If Separated/Divorced,** who has legal custody/medical making decision rights for this child: _____

## *Primary Issue(s):*

- Explain in as much detail as possible what issues your child has been experiencing: (Please include: How long symptoms have been occurring, approximate date of onset, location on body, what aggravates it, and what relieves it)

  _____

  _____

- Is the problem getting: ☐Better ☐Worse ☐Unchanged (Explain) _____
- Have any studies been done: ☐X-Ray ☐MRI ☐CT Scan ☐Labs (Explain) _____

**Other providers seen/treatments preformed:** ☐Pediatric ☐Osteopathic ☐Chiropractic ☐PT ☐OT ☐Medications (*Explain what has been done*):_____

_____

## *Pregnancy and Birth History:*

- Child is yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other _____
- Pre-Natal Care: ☐N ☐Y Medications during pregnancy ☐N ☐Y What/ReasonFor: _____
- Age of Mother at pregnancy: _____ # Pregnancy: ☐1st ☐2nd ☐3rd ☐Other ____ Problems Prior to Pregnancy ☐N ☐Y
- Smoked while pregnant: ☐N ☐Y #Per Day ___ Used Recreational Drugs while pregnant ☐N ☐Y(Type) _____
- Drank Alcohol while pregnant: ☐N ☐Y ☐Wine/Beer ☐Spirits/Liquor #Per Week: _____
- Complications during pregnancy ☐None ☐High Blood Pressure ☐Diabetes ☐Edema ☐Pre-Eclampsia ☐Eclampsia
- Any pain/bleeding during pregnancy: ☐Y ☐ (If yes, Explain) _____
- Events Occured/Drugs Used During Labor/Delivery: (Complications) _____
  ☐Pitocin ☐Epidural ☐Vacuum ☐Forceps ☐VD Induced ☐C-Section ☐Nuchal Cord ☐Premature _____

- Duration of Pregnancy: _____ Duration of Labor:_____ Duration of Pushing: _____

- Apgar scores: _____ _____

## *Immunizations/Vaccinations:* (What type of schedule, if any, was or is being followed)

☐Recommended Schedule ☐Delayed Schedule: (Explain) _____ ☐None Given

Any adverse reactions: ☐N ☐Y (If yes, what reactions) _____

## *Dental History:* Seen by dentist ☐N ☐Y How Often _____

☐Braces ☐Head Gear ☐Expander ☐Tooth Extractions ☐Fillings ☐Root Canals ☐Crowns ☐Other _____
Overall Dental Health: Excellent☐ Good☐ Fair☐ Poor☐



Provider Initials_____

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Child's Name: _____ Date: _____

## *Trauma/Accident History:*

Concussions/Head Injuries ☐N ☐Y (If yes how many) _____ Explain: _____

Motor Vehicle Accidents: ☐N ☐Y (If yes, how many) _____ Explain: _____

Injuries such as (Sports, Falls etc.): ☐N ☐Y_____

Emotional trauma: ☐N ☐Y _____

Sexual Abuse ☐N ☐Y Physical Abuse ☐N ☐Y Neglect☐N ☐Y(explain)_____

Reported ☐N ☐Y _____ Child had/having therapy/treatment ☐N ☐Y _____ Resolved ☐N ☐Y ☐Ongoing

## *Current or Significant Medical Problems:*

1. _____
2. _____

## *Hospitalizations or Surgeries:* (Examples: Sinus/Ear/Tonsils/Adenoids/Appendix/Fracture Repair/Dental/Other)

| | **Hospital** | **Date** | **Surgery/Treatment** | **Diagnosis** |
|---|---|---|---|---|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |

**Family Health History:** Include immediate blood relatives, i.e. parents/grandparents/aunts/uncles, siblings
Parent's: Ages and Health Status: _____

| ✓ | Disease/Illness | Who | Alive Deceased | ✓ | Disease/Illness | Who | Alive Deceased |
|---|---|---|---|---|---|---|---|
| | Cancer | | ☐A ☐D | | Alcohol/Drug Abuse | | ☐A ☐D |
| | Diabetes I or II | | ☐A ☐D | | Thyroid Disease | | ☐A ☐D |
| | Heart Disease Type: | | ☐A ☐D | | Autoimmune Disorders Type: | | ☐A ☐D |
| | High/Low Blood Pressure | | ☐A ☐D | | Liver Disease | | ☐A ☐D |
| | High Cholesterol | | ☐A ☐D | | Kidney Disease | | ☐A ☐D |
| | Heart Attack/Stroke/TIA | | ☐A ☐D | | Thyroid Disease | | ☐A ☐D |
| | Anxiety/Depression | | ☐A ☐D | | Osteoporosis | | ☐A ☐D |
| | Mental Illness Type: | | ☐A ☐D | | Rheumatoid Arthristis | | ☐A ☐D |
| | Infectious Diseases Type | | ☐A ☐D | | Allergies | | ☐A ☐D |
| | Asthma/Respiratory | | ☐A ☐D | | Other | | ☐A ☐D |

## *History of Child's Symptoms*

**Does your child have or has your child experienced any of the following:** (Please Tick which apply)
Antibiotics☐(How many courses) _____ Scoliosis/Short Leg☐ Arthritis☐ Cystic Fibrosis☐ Multiple Sclerosis☐
ADD/ADHD☐ Sensory Integration Problems☐ Autistic Spectrum Disorder☐ Tourette's☐ Asperger's Syndrome☐
Eating Disorder's☐ Obesity☐ Diabetes Type I ☐ Diabetes Type II☐ Substance or Alcohol Abuse☐



Provider Initials_____

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Patient Name:_____ Date: _____

**CURRENT MEDICATIONS:** *Please list Drug & Dose or* ☐ **None**

| | |
|---|---|
| | |
| | |
| | |
| Is your child Sensitive/Allergic/Intolerant to any of the following foods (Please Circle) | Milk/Dairy Wheat/Gluten Peanuts Soy Eggs Corn Yeast Chocolate Fish/Shellfish Citrus |

**SUPPLEMENTS** ☐ **None**

| |
|---|
| |
| |
| |
| |

**Allergies/Reactions to Medications:** ☐N ☐Y (Hives, Rash, Breathing Difficulties, Other)

_____

## *Social History:*

Environmental exposures: ☐Smoking ☐Pets ☐Other _____

Quality of home life: _____

School - Does your child enjoy school: ☐N ☐Y

Does your child perform well academically: ☐N ☐Y (if No, Explain) _____

Does your child like sports/physical activity: ☐N ☐Y (what Sports) _____

Like games/crafts/music: ☐N ☐Y (Give Examples) _____

Good Social Skills with peers/adults: ☐N ☐Y (If No, Explain) _____

***Please describe your child's personality/temperament:*** _____

_____

## *Diet:*

**As an Infant:**

Child was/is: Breast Fed☐ Breast/Bottle Fed☐ Formula/Bottle Fed☐

If Breast Fed, did/does child latch on easily: ☐N ☐Y

Did/does your child experience Colic: ☐N ☐Y

At what age did you start your child on Solid Foods: _____

**1 year plus:**

How much Fruit per day/week: _____ Vegetables: _____ Meat: _____

Does your child have a special diet (Low Fat, Vegetarian, Gluten Free etc.): _____

How much water does your child drink per day: _____

Soda's per day/week: _____

Caffeine: _____

**Sensitivities to Food/Environment** ☐N ☐Y Explain _____

## *Habits:*

Wear a Seatbelt: ☐N ☐Y Bicycle Helmet: ☐N ☐Y How many Hours Sleep Per ☐ Night:

Sleep Habits: _____ Sleep Quality: _____

**Anything else to share:** _____

_____

_____



Provider Initials_____

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| **Review of Systems** | **Yes, Now** | **Yes, Past** | **Never** | **Review of Systems** | **Yes, Now** | **Yes, Past** | **Never** |
|---|---|---|---|---|---|---|---|
| **1.Constitutional** | | | | **8.Urinary** | | | |
| Excessive Weight Loss | | | | Frequent Urination | | | |
| Excessive Weight Gain | | | | Painful Urination | | | |
| Loss of or Poor Appetite | | | | Blood in Urine | | | |
| Change in Sleep Habits | | | | Urinary Tract Infections | | | |
| Excessive Fatigue | | | | Bed Wetting | | | |
| **2.Eyes** | | | | **9.Integumentary/Skin** | | | |
| Vision Changes | | | | Frequent Rashes | | | |
| Cross Eyed | | | | Eczema/Psoriasis | | | |
| Problems with Squinting | | | | Acne | | | |
| Wears Glasses/Contacts | | | | **10.Neurologic** | | | |
| **3.Ear, Nose, & Throat** | | | | Problems w/Dizziness | | | |
| Hearing Problems | | | | Head Injuries/Concussions | | | |
| Frequent Ear Infections | | | | Headaches/Migraines | | | |
| Strep Throat | | | | Epilepsy/Seizures | | | |
| Sore Throat | | | | **11.Immunologic** | | | |
| Frequent Nose Bleeds | | | | Seasonal Allergies | | | |
| Snoring Problems | | | | Food Allergies | | | |
| Dental Problems | | | | Red Itchy Eyes | | | |
| **4.Cardiovascular** | | | | **12.Musculoskeletal** | | | |
| Heart Defect | | | | Broken Bones | | | |
| Heart Murmur | | | | Sprains | | | |
| Rapid Heart Beat/Palpitations | | | | Coordination Problems | | | |
| **5.Respiratory** | | | | Curvature of Spine | | | |
| Shortness of Breath | | | | Posture Problems | | | |
| Difficulty Breathing | | | | Joint Pain | | | |
| Chronic Cough | | | | **13.Endocrine** | | | |
| Wheezing | | | | Excessive Thirst | | | |
| Asthma | | | | Cold Intolerance | | | |
| **6.Gastrointestinal** | | | | Heat Intolerance | | | |
| Problems w/Diarrhea | | | | Excessive Sweating | | | |
| Constipation | | | | Swollen Glands/Lymph Nodes | | | |
| Blood in Stool | | | | **14.Mental Health** | | | |
| Frequent Nausea/Vomiting | | | | Agitation/Irritability | | | |
| Heartburn/Reflux | | | | Anxiety/Depression | | | |
| Abdominal Pain | | | | Frequent Crying | | | |
| **7.Hematologic/Lymphatic** | | | | Trouble w/Focus & Attention | | | |
| Frequent Bruising | | | | Hyperactive/Underactive | | | |
| Cuts Bleed for Long Time | | | | Nail Biting/Hair Pulling | | | |
| Swollen Lymph Nodes | | | | History of Cutting | | | |



Provider Initials_____