

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

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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:

- _____
- _____

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

<u>Hospital</u>	<u>Date</u>	<u>Surgery/Treatment</u>	<u>Diagnosis</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Family Health History: Include immediate blood relatives, i.e. parents/grandparents/aunts/uncles, siblings

Parent's: Ages and Health Status: _____

<input checked="" type="checkbox"/>	Disease/Illness	Who	Alive Deceased	<input checked="" type="checkbox"/>	Disease/Illness	Who	Alive Deceased
	Cancer		<input type="checkbox"/> A <input type="checkbox"/> D		Alcohol/Drug Abuse		<input type="checkbox"/> A <input type="checkbox"/> D
	Diabetes I or II		<input type="checkbox"/> A <input type="checkbox"/> D		Thyroid Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	Heart Disease Type:		<input type="checkbox"/> A <input type="checkbox"/> D		Autoimmune Disorders Type:		<input type="checkbox"/> A <input type="checkbox"/> D
	High/Low Blood Pressure		<input type="checkbox"/> A <input type="checkbox"/> D		Liver Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	High Cholesterol		<input type="checkbox"/> A <input type="checkbox"/> D		Kidney Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	Heart Attack/Stroke/TIA		<input type="checkbox"/> A <input type="checkbox"/> D		Thyroid Disease		<input type="checkbox"/> A <input type="checkbox"/> D
	Anxiety/Depression		<input type="checkbox"/> A <input type="checkbox"/> D		Osteoporosis		<input type="checkbox"/> A <input type="checkbox"/> D
	Mental Illness Type:		<input type="checkbox"/> A <input type="checkbox"/> D		Rheumatoid Arthritis		<input type="checkbox"/> A <input type="checkbox"/> D
	Infectious Diseases Type		<input type="checkbox"/> A <input type="checkbox"/> D		Allergies		<input type="checkbox"/> A <input type="checkbox"/> D
	Asthma/Respiratory		<input type="checkbox"/> A <input type="checkbox"/> D		Other		<input type="checkbox"/> A <input type="checkbox"/> 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

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Patient Name: _____ Date: _____

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

SUPPLEMENTS 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

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

Sleep Habits: _____ Sleep Quality: _____

Night:

Anything else to share: _____

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<u>Review of Systems</u>	Yes, Now	Yes, Past	Never	<u>Review of Systems</u>	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			