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☐

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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: _____

_____

_____

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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_____