MEDICAL HISTORY (PEDIATRIC)

Date:_____

Patient Name:_____ Date of Birth:_____

Home Address: _____ ☐ Female ☐ Male
Street

_____
City State Zip Code

Parent's Phone: _____ _____ _____
Home Work Email (parent's or guardian)

Guardian's/Parent's Name: _____

Was child adopted: Y N Is there a current custodial case? Y N If yes, who has current custody: _____

Who (is) are authorized to bring child (patient) to appointments and discuss about medical concerns, and can have request medical records?

_____

****

Emergency Contact Information

Name:_____ Relationship:_____

Address:_____Phone:_____

****

How did you hear about us? _____

Have worked with a Naturopathic Doctor in the past? _____If yes, when?_____

List in order of importance of your health concerns:
1)
2)
3)

Last Physician Exam: _____ Physician & Phone #:_____

Last Dental Exam: _____ Dentist & Phone #:_____

Last Vision Exam: _____ Last Lab Work-Up: _____

X-rays, Ultrasounds, MRI/CT Scan (when and why):_____

List all Surgeries & Hospitalizations, including dates occurred:

1) _____ 3)_____

2) _____ 4)_____

List any allergies (medications, foods, pollen, animals, etc): _____

Medications/Supplements History: P (past), C (current)

	P	C	Frequency
Aspirin	☐	☐	_____
Tylenol	☐	☐	_____
Antibiotics	☐	☐	_____
Benadryl	☐	☐	_____
Decongestants	☐	☐	_____

	P	C	Frequency
Vitamins	☐	☐	_____
Fluorides	☐	☐	_____
Herbs	☐	☐	_____
Homeopathy	☐	☐	_____
_____	☐	☐	_____

List all **current** medications & dosages (including herbs, supplements, Over-the-Counter):_____

MEDICAL HISTORY (PEDIATRIC)

Vaccination History: Please check (✓) if you have had disease, got immunized or was never exposed

	Measles	Mumps	Rubella	Tetanus	Pertussis	Whooping cough	Hemophilus (Hib, B)	German measles	Chicken pox (varicella)	Hepatitis B	Pneuomonia	Strept Throat	Polio	HPV	Other:
Had Disease															
Got immunized															
Never Exposed															

Has child had any reactions to vaccinations? If yes, what happened? _____

Patient's Medical History: Please check (✓) if you experienced the symptoms in the Past (P) Current (C) Never (N)

	P	C	N
Jaundice as baby	☐	☐	☐
Cradle cap	☐	☐	☐
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
Acne	☐	☐	☐
Stomachache	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Vomiting	☐	☐	☐
Picky eating	☐	☐	☐
Poor teeth/dentition	☐	☐	☐
Congestion	☐	☐	☐
Chronic post nasal drip	☐	☐	☐
Foot odor	☐	☐	☐
High fever	☐	☐	☐
Sweaty	☐	☐	☐

	P	C	N
Hyperactivity	☐	☐	☐
ADHD/ADD	☐	☐	☐
Autism/Asperger's	☐	☐	☐
Learning disorder	☐	☐	☐
Colic	☐	☐	☐
Tantrums	☐	☐	☐
Joint pains	☐	☐	☐
Growing/bone pains	☐	☐	☐
Fatigue	☐	☐	☐
Anemia	☐	☐	☐
Asthma	☐	☐	☐
Cough	☐	☐	☐
Wheezing	☐	☐	☐
Colds/flu	☐	☐	☐
Allergies	☐	☐	☐
Ear infections	☐	☐	☐

	P	C	N
Tonsilitis	☐	☐	☐
Warts	☐	☐	☐
Nightmares	☐	☐	☐
Epilepsy/seizures	☐	☐	☐
Depression	☐	☐	☐
Bed-wetting	☐	☐	☐
Fears/phobia	☐	☐	☐
Headache	☐	☐	☐
Birth defects	☐	☐	☐
Heart murmur	☐	☐	☐
Other heart conditions	☐	☐	☐
Frequent infections	☐	☐	☐
Thrush	☐	☐	☐
Diaper rash	☐	☐	☐
Early puberty	☐	☐	☐
Exposure to cigarettes	☐	☐	☐

Other health conditions: _____

Hearing Tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Speech Impediments: Yes No Past

Learning Impediments: Yes No Past

When did child start walking:_____

When did child start talking: _____

When did child develop first tooth: _____

What is your child's overall disposition: _____

Prenatal/Birth/Feeding History Please **check (✓) or circle** all the apply

Mother's Pregnancy History

Age of Conception:_____ Pregnancy Complications: _____

Medications/Supplements during pregnancy: _____

	Bleeding		Diabetes		Preeclampsia		Smoking
	Nausea/Vomiting		Emotional stress		Toxemia		Coffee
	Trauma		Illness		Recreational Drugs		Alcohol

Length of Labor: _____ Birth: Vaginal C-Section Term: Full-term Premature

Feeding: Breast milk How long: _____ Formula What formula was used: _____

When was solid food introduced: _____ Any food allergies, sensitivities, intolerances: _____

Child's typical diet includes:

Breakfast	**Lunch**	**Dinner**	**Snack**

MEDICAL HISTORY (PEDIATRIC)

Family History: Please check (✓) if any family member(s) and patient have had any of the following health conditions

Medical Conditions:	Patient	Father	Mother	Grandparents	Sibling:	Sibling:	Sibling:
If Living: Age							
If Deceased: Age & Cause							
High Blood Pressure							
Heart Attack/Stroke							
Heart Disease							
High Cholesterol							
Obesity							
Thyroid Disease							
Asthma/Allergies							
Eczema							
Tuberculosis							
Auto-Immune Disease							
Diabetes Mellitus							
Hepatitis							
Osteoporosis							
Cancer							
Depression							
Mental Illness							
Addiction/Alcoholism							
Seizure/Epilepsy							
Anemia							
Bleeding disorder							
Arthritis							
Glaucoma							
Cataracts							
Other:							

Social History

Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Who does child live with: _____

Mother's Occupation: _____ Father's Occupation: _____

Other Guardian: _____ Relationship: _____

Does child any siblings? If yes, how many & age? _____

_____

Daycare/School: _____ How many hours/day: _____ How many days/wk: _____

Any Particular household stressors child has witnessed or gone through:

1) 2)

3) 4)

Toxin Exposure

Has the child ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all?

_____

Does the child seem particularly sensitive to perfumes, gasoline or other vapors? _____

Do you spray pesticides, herbicides or other chemicals around your home? _____