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):____

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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**

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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? ____