PEDIATRIC HEALTH HISTORY FORM

(Birth - 5 years)

Kristin Stiles Green, NMD

Patient's name _____ Date _____

Age _____ Date of Birth _____ Gender: female _____ male _____

Mother's name_____ Father's name _____

Address _____

Phone #'s (home) _____(cell) _____

Email addresses_____

Is there anyone we can thank for referring you here? _____

Name of Doctor's office/Clinic where your child's former health records are kept:

_____

Reason(s) for your visit today: _____

_____

_____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestants	_____	_____	Other	_____	_____
Ibuprofen	_____	_____	Allergies to medicines	_____	

MEDICAL HISTORY

_____ Chicken pox	_____ Scarlet fever	Tonsillitis, approx. no. _____
_____ Measles	_____ Pneumonia	Ear infections, no. _____
_____ Mumps	_____ Frequent colds	Other (please list) _____
_____ Rubella	_____ Rheumatic fever	Allergic reactions_____

Has your child had any of the following tests? When Where Results

Electroencephalogram
Psychological evaluation
Hearing
Speech/Language

Injuries/Surgeries/Hospitalizations (please list): _____

_____

_____

IMMUNIZATIONS

What immunizations has your child had or is he/she current on his/her vaccination schedule?

_____

Any adverse reactions to immunizations? ☐ Y ☐ N What were the reactions?

_____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Hypertension
_____ Cancer _____ Allergies _____ Mental illness

PRENATAL HISTORY

Previous pregnancies by birth mother; miscarriages or complications? _____
Mother's age at child's birth? _____
Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Pre-mature _____ Late_____ Weight at birth_____

Length of labor _____ Complications? _____

Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ "Blue baby" syndrome
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____

_____

_____

Child's sleep patterns (first year) _____

Food intolerance (if any) _____

Feeding: Breast-fed? ☐ Y or ☐N How long? _____ Formula? ☐ Y ☐ N What type? _____

or Age began solid foods _____ Which foods, first? _____

Age began: Sitting _____ Crawling_____ Walking_____ Talking_____

SYMPTOMS (mark Y if current, P for past symptoms)

_____ Hives	_____ Burning of urine	_____ Blood in urine
_____ Eczema	_____ Frequent urination	_____ Cries easily
_____ Bleeding gums	_____ Heart murmur	_____ Nervous
_____ Nose bleeds	_____ Vomiting spells	_____ Sleep problems
_____ Acne	_____ Anemia	_____ Night sweats
_____ High fevers	_____ Stomachaches	_____ Sensitive to light
_____ Chronic rash	_____ Jaundice	_____ Body/breath odor
_____ Hearing loss	_____ Easy bruising	_____ Motion/car sickness
_____ Diarrhea	_____ Flat feet	_____ No appetite
_____ Sore throats	_____ Constipation	_____ Nightmares
_____ Headaches	_____ Gas	_____ Canker sores
_____ Frequent colds	_____ Bleeding tendency	_____ Unusual fears
_____ Wheezing	_____ Joint pains	_____ Excessive fatigue
_____ Cough	_____ Dizzy spells	_____ Hair loss

DIET

Please describe your child's typical, daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Is there anything else you would like to add?

_____

_____

_____

_____

Welcome! We look forward to working with you and your child.