Pediatric Health History: Infant or Child, age 5 or younger
Roots WellCare, P.A.

Child's Name:____ **Date**:___________________

Family Medical History: Please indicate if any blood relatives of the child had any of the following illnesses, and note which relative by marking M (Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); MGM (Maternal Grandmother); PGF (Paternal Grandfather); or MGF (Maternal Grandfather).
(If family history is unknown or limited because child is adopted, please check here: ________)

_______Allergy, Asthma or Eczema
_______Cancer
_______Diabetes or Low Blood Sugar
_______Heart Trouble
_______High Blood Pressure / Stroke
_______Kidney Disease
_______Liver Disease
_______Mental Retardation
_______Mental Illness
_______Scoliosis
_______Ulcer
_______Other ________________________

Pregnancy: Please check any areas that applied to the child's mother during pregnancy:

_______Complications
_______Medications
_______Recreational Drugs
_______Smoking
_______Alcohol
_______Caffeine: Cola
_______Caffeine: Coffee
_______Caffeine: Chocolate
_______Caffeine: Other
_______Vitamins / Minerals
_______Any Diagnosed Illnesses
_______Hospitalization
_______Immunization
_______Excessive bleeding
_______Premature Contractions
_______Back Pain
_______Other Pain
_______Excessive Weight Loss
_______Excessive Weight Gain
_______Toxic Exposures
_______Allergic Reactions
_______Mental Trauma
_______Physical Injury
_______Prenatal Classes
_______Chiropractic Care
_______Carried to Full Term
_______Mood - Mostly Happy
_______Mood - Mostly Depressed

Labor and Delivery

_______Labor longer than 12 hours
_______Complications
_______Fetal Monitor Used
_______Medications
_______Forceps
_______Other____________________
_______Caesarean
_______Hospital
_______Home Birth
_______Premature Delivery
_______Vacuum Extraction
_______How Many Hours Pushing?

Duration of the pregnancy: _______weeks
*APGAR score at birth: ________________
APGAR score at five minutes: _________________
Length at birth: ________________________
Birth weight: _______________________________

(*APGAR = Appearance, Pulse, Grimace, Activity, Respiration)

Please check any problems the child had at birth or shortly after:

_______Breathing	_______Nursing	_______Color (gray, blue, pale, etc)
_______Sleeping	_______Jaundice	_______Crying
_______Choking	_______Medication	_______Artificial Feeding (bottle)
_______Erythromyocin	______Vitamin K	_______Other___________________ (Please explain)

Nutrition

Please check if the child has received:

_____Breast milk: how long?_______	_____Solid foods
_____Formula: type?_____________	_____Vitamins
_____Cow's milk	_____Medications: (name)____________________
_____Goat milk	_____Juice: fruit vegetable (circle one or both)
_____Other milk__________	_____Sweets

Immunizations

Type	Date(s)	Reaction(s) observed
MMR	____________________	______________________________
DPT	____________________	______________________________
Hepatitis A and/or B	____________________	______________________________
Polio	____________________	______________________________
Chickenpox	____________________	______________________________
Hib (Haemophilus)	____________________	______________________________

Any foreign travel with the child?___________

Illnesses and Hospitalizations

_______Illnesses (please explain) ____

_______Surgery (please explain) ____

_______Circumcision

Family Pediatrician

Name of pediatrician and date of last exam: ____

General System Review

Has your child ever been unconscious or had a convulsion? _____________________________

Any problems with the eyes, including vision?____

Has your child ever been cyanotic (turned blue)?______________________________________

Does your child tolerate exercise? ____

Any recurring problem with vomiting, diarrhea, constipation or stomach pain? ______________

Do the stools look or smell abnormal?____

Any unusual problem on passing urine or any unusual frequency?_________________________

Any unusual smell or appearance of urine?____

Does your child complain of any extremity or back pain? Do you notice a limp or unusual gait pattern?

____

Any allergies, eczema, hay fever, hives, asthma, or drug reactions?________________________

____

Has your child had any ear infections? Please note frequency, approximate dates: ____________

____

Other problems?____