

Pediatric Health History

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	_____ Liver Disease
_____ Cancer	_____ Mental Retardation
_____ Diabetes or Low Blood Sugar	_____ Mental Illness
_____ Heart Trouble	_____ Scoliosis
_____ High Blood Pressure / Stroke	_____ Ulcer
_____ Kidney Disease	_____ Other _____

Pregnancy

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

_____ Complications	_____ Premature Contractions
_____ Medications	_____ Back Pain
_____ Recreational Drugs	_____ Other Pain
_____ Smoking	_____ Excessive Weight Loss
_____ Alcohol	_____ Excessive Weight Gain
_____ Caffeine: Cola	_____ Toxic Exposures
_____ Caffeine: Coffee	_____ Allergic Reactions
_____ Caffeine: Chocolate	_____ Mental Trauma
_____ Caffeine: Other	_____ Physical Injury
_____ Vitamins / Minerals	_____ Prenatal Classes
_____ Any Diagnosed Illnesses	_____ Chiropractic Care
_____ Hospitalization	_____ Carried to Full Term
_____ Immunization	_____ Attitude - Mostly Happy
_____ Excessive bleeding	_____ Attitude - Mostly Depressed

Labor and Delivery

_____ Labor longer than 12 hours	_____ Caesarean
_____ Complications	_____ Hospital
_____ Fetal Monitor Used	_____ Home Birth
_____ Medications	_____ Premature Delivery
_____ Forceps	_____ Vacuum Extraction
_____ Other _____	_____ How Many Hours Pushing?

The duration of the pregnancy was _____ weeks.

The apgar score at birth was _____.

The apgar score at five minutes was _____.

The length at birth was _____.
The birth weight was _____.

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

_____ Breathing _____ Nursing _____ Color (gray, blue, pale, etc)
_____ Sleeping _____ Jaundice _____ Crying
_____ Choking _____ Other (please explain) _____

Please check if any of the following applied to the child at birth or shortly after:

_____ Medication _____ Artificial Feeding (bottle)
_____ Erythromycin _____ Vitamin K
_____ Other _____
(Please explain)

Nutrition

Please check if the child has received:

_____ Breast milk: how long? _____
_____ Formula: type? _____
_____ Cow's milk _____ Solid foods
_____ Goat milk _____ Vitamins
_____ Other milk _____
_____ Medications: (name) _____
_____ Juice: fruit vegetable (circle one or both)
_____ Sweets

Immunizations

<u>Type</u>	<u>Date(s)</u>	<u>Reaction(s) observed</u>
MMR	_____	_____
DPT	_____	_____
Hepatitis B	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

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