THE WOMEN & CHILDREN'S NATURAL HEALTH CENTER

PEDIATRIC MEDICAL HISTORY

Please provide a copy of your child's Immunization records Date ____________________________

Child's Name ______________________________________ Date of Birth _____/_____/________

Sex: ☐ Male ☐ Female. Birthplace: ☐ Home ☐ Hospital. Is the child yours by: ☐ Birth ☐Adopted ☐ Other

Mother's Name ______________________________________ Father's Name ______________________________________

Address ____ Child lives with: ☐ Both Parents ☐ Mom ☐ Dad ☐ Other

____ Home Phone ______________________________________

____ Work Phone ______________________________________

Sibling's names and ages ____

Current Physician _____________________________________ Prior Physician ____________________________________

Current Medical Concerns

Reason for visit ____

Is your child currently being treated for any other medical condition or illness? ☐ Y ☐ N

____

Is your child currently taking any medications? List current medications and dose:________________________________

____

Allergies (to medicine/ vaccines, list and describe reaction ____

Known Food Allergies ______________________________________ Enviornmental Allergies _____________________

____

Special Diet or Food Restrictions ____

Child's Past Medical History

Child's birth weight (lbs) ______________ Length at birth ______________ Delivered by: ☐ Vaginal birth ☐ C-Section

Please list any pregnancy complications ____

Maternal Information During Pregnancy Was your child premature? _______________

Caffeine use: Type ____________ Amount/ Day _________ Alcohol use: Type ____________ Amount/ Day ________

Tobacco use: Type ____________ Amount/ Day _________

Medication use: Non Prescription Type/ strength __________________ Amount/ Day ________

Prescription Type/ strength __________________ Amount/ Day ________

During this pregnancy did you have: (Circle all that apply)

Prenatal Care High Blood Pressure Gestational Diabetes Venereal Disease

German (3 day) Measles Any Illness, Infection or High Fever (If yes, describe____________________________)

Signature of Guardian ____

Infant Health History (Birth to 3 Months)

Age when discharged from Hospital _________ Was your baby Jaundiced? ☐ No ☐ Yes, age ____ how long ______

Breastfed ☐ No ☐ Yes, _______ months/ Formula Fed ☐ No ☐ Yes, ________ months Formula Name _________

Has your child had any unusual feeding/ dietary problems? Explain: ____

Developmental History

At what age did your child: Lift head _________ Roll over _________ Sit alone_________ Stand up ___________

Walk alone _________ Drink from cup __________ Say words __________ Toilet Train ___________

Review of Systems Has your child ever had: (Circle all that apply)

Constitutional: Fever, Chills, Fatigue, Recent weight changes, Headaches, Excess thirst, Hot or Cold intolerances

Diseases: Measles (10 day), Rubella (3 day measles), Mumps, Chicken Pox, Whooping Cough, Rheumatic Fever, Hepatitis (Liver Disorders) Bronchitis or Chronic Cough, Asthma, Pneumonia , Anemia/Blood Disorders

Eyes: Crosses or Wandering eyes, Vision problems, Eye irritation, Frequent headaches, Eye drainage, Squinting, Wears glasses/contact lenses

Ears/Nose/Mouth/Throat: Frequent ear infections, Hearing problems, Ear pain, Runny nose, frequent nose bleeds, frequent stuffed up nose, snoring, mouth breathing, difficulty talking, stuttering, frequent colds or sore throats, persistent hoarseness, dental problems Date of last dentist visit _______________

Cardiovascular: Shortness of breath, chest pain, palpitations

Gastrointestinal: Loss of appetite, Change in bowel movements, nausea, vomiting, diarrhea, constipation, worms, blood in stool, abdominal pain

Genitourinary: Urination problems, painful/ burning urination, blood in urine, unusual urine order, persistent diaper rash, bedwetting problems, discharge from vagina or penis, (Females) 1st period age ____________

Integumentary (skin): Rash or itching problems, change in hair or nails, slow healing bruises, abnormal moles, cuts easy, bruises after bleeding

Musculoskeletal: Painful or swollen joints, sprains/dislocations/broken bones, muscle coordination/strength problems, posture problems

Neurological: Dizzy or fainting spells, periods of confusion or disorientation, convulsions/ seizures, tremors/shakes, difficulty walking/balancing/handling objects, head injuries, developmental milestone delays

Psychiatric: Frequent nightmares, unusually nervous or high strung, irritable/ temper problems, extreme mood swings, unusually disobedient, problems at school or with friends, suicidal attempt(s)

Family History Do any family members have any of the following conditions:

CONDITION	Mother	Father	Sibling	Grandparents
Asthma	_________	__________	_________	__________
Anemia	_________	__________	_________	__________
Blood Disorder	_________	__________	_________	__________
Cancer	_________	__________	_________	__________
Heart Problems	_________	__________	_________	__________
High Blood Pressure	_________	__________	_________	__________
Stroke	_________	__________	_________	__________
Diabetes	_________	__________	_________	__________
Thyroid Disease	_________	__________	_________	__________
Kidney Disease	_________	__________	_________	__________
Seizure	_________	__________	_________	__________
Migraines	_________	__________	_________	__________
Depression/Anxiety	_________	__________	_________	__________
Alchoholism/Drugs	_________	__________	_________	__________
ADD/ ADHD	_________	__________	_________	__________
Birth Defects	_________	__________	_________	__________
Allergies	_________	__________	_________	__________

Please explain all above positives ____

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