

NW PEDIATRICS

INTEGRATIVE MEDICINE

PATIENT HEALTH HISTORY

Date _____

Patient's Last	First	MI	Age	Date of Birth
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Pregnancy, Birth, and Newborn

1. Did you have an illness during your pregnancy? NO YES
2. Did the baby come on time? NO YES
3. How old were you when the baby was born? _____ Years
4. How many times have you been pregnant? _____
5. What was the birth weight? _____ lbs. _____ ozs.
6. Did your baby have any trouble starting to breath? NO YES
7. Did your baby have any trouble in the hospital? NO YES

Medical History

1. Was there severe colic or any unusual feeding problem in the first three months? NO YES
2. Is your child's appetite usually good? NO YES
3. Do any foods disagree with your child? NO YES
4. Has constipation ever been much of a problem? NO YES
5. Does your child take any medicine? NO YES
6. Has he/she had any allergies or reactions to any medicines or injections? NO YES
7. Has he/she ever had eczema or hives? NO YES
8. Has he/she ever had wheezing or asthma? NO YES
9. Does he/she tend to have a stuffy nose or "constant cold"? NO YES
10. Has your child had as many as three bouts of ear trouble? NO YES
11. Does he/she have more than three colds or throat infections a year with fever? NO YES
12. Does he/she hear well? NO YES
13. Does he/she have any trouble passing urine? NO YES
14. Has he/she ever had a convulsion or fit? NO YES
15. Has he/she had any trouble with his/her eyes? NO YES
16. Has he/she had any trouble with his/her teeth? NO YES
17. Is there anything wrong with the way he or she walks? NO YES
18. Check any of the following that your child has had:

- | | |
|--|--|
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Serious Accidents |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Removal of Adenoids and Tonsils | |

Other Operations:

Other Diseases (Explain):

Hospitalizations (Purpose):

Developmental History

1. At what age did he/she sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was eighteen months old? NO YES
4. If you did not know your child's age, how old would you guess him/her to be by the way he/she acts? _____
5. Is he/she doing well in school? NO YES
6. Does he/she get along well with other children? NO YES
7. Check any of the following problems which your child has:

<input type="checkbox"/> Wets Bed	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Won't Toilet Train	<input type="checkbox"/> Breath-Holding	<input type="checkbox"/> Destructive
<input type="checkbox"/> Wetting During the Day	<input type="checkbox"/> Temper Tantrums	<input type="checkbox"/> Mean to Animals
<input type="checkbox"/> Nervous Habits of Any Kind		

Family History

1. List first name, age, general health, and years of education of the child's parents:

Mother

Father

2. List names, age, sex, and general health of child's brothers and sisters:

1. _____
2. _____
3. _____
4. _____

3. Have any of your children died? NO YES

4. Check any of the following diseases that this child's parents, brothers, sisters, grandparents, aunts, uncles, or first cousins have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Early Death |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Inherited Diseases |
| <input type="checkbox"/> Deformities | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures | | |

5. What doctors have taken care of your child in the past? _____