YOUR CHILD'S HEALTH HISTORY

Dear Parents,

By filling out this questionnaire, a more complete record of your child is obtained, and it gives us a permanent history which we can refer to later. Answer all the questions you can, but don't worry about those you skip.

PATIENT'S NAME ______________________________________ TODAY'S DATE ___________________

Patient's Birthdate ___________ Age ______ □ Male □ Female Birthplace ___________________________

MEDICAL HISTORY

Check any of the following your child has had:

	What age?	Please describe
□ Emergency Room visit	__________	______________________________
□ Broken bones	__________	______________________________
□ Stitches	__________	______________________________
□ Surgery	__________	______________________________
□ Hospital overnight	__________	______________________________
□ Specialist physician	__________	______________________________

□ chicken pox	□ heart problem	□ bladder infection	□ fever seizure	□ mental illness
□ chronic ear infection	□ anemia	□ kidney problem	□ diabetes	□ behavior problem
□ hearing problem	□ blood transfusion	□ wetting pants	□ thyroid problem	□ speech problem
□ asthma	□ abdominal pain	□ skin problem	□ cancer	□ dental problem
□ lung problem	□ constipation	□ frequent headaches	□ learning problem	□ snoring
□ pneumonia	□ soiling pants	□ frequent colds	□ ADD, ADHD	□ glasses
□ excessive bruising	□ diarrhea	□ convulsions/seizures		

Has your child had any allergic reactions to any medicines, injections, foods, animals, insects, or plants? Please list:____

____

Does your child take medications? Please list:

____

____

PREGNANCY, BIRTH AND NEWBORN HISTORY

1. Who was the doctor who delivered this child?____
2. Was this child born on time? No Yes
3. Was this baby born □ head first □ legs first □ C-section?
4. Did the mother have an illness during her pregnancy? Yes No
5. How old was the mother when the baby was born? ______ Years
6. How many times had the mother been pregnant? ______ times
7. How many hours did the labor last? ______ hours
8. Did this baby have any trouble starting to breathe? Yes No
9. Did this baby have any trouble while in the hospital? Yes No
10. How long did your baby stay in the hospital? ______ days

DIET HISTORY

1. How long did your infant breast or bottle-feed? ____________________________________
2. What formula was used in the first year? _________________ Problems? _________________________
3. Does your child have food allergies? _______________________________________ Yes No
4. Does your child like/eat meat? Amount per day: __________________________________ Yes No
5. Does your child like/eat dairy products? Amount per day: _________________________ Yes No

6. Does your child like/drink juice? Amount per day: ______________________________ Yes No
7. Does your child always eat breakfast? Yes No
8. Does your child take any dietary supplements, herbs, or health store products? Yes No
   Please list: ____

DEVELOPMENTAL HISTORY

1. At what age did your child sit alone? ______________________________________
2. At what age did your child walk alone? ____________________________________
3. Did he/she say words by the time he/she was 18 months old No Yes
4. If you did not know your child's age, how old would you guess your child to be by the way your child acts? ______________________________________
5. Is your child doing well in school? Yes No
6. Does your child get along well with other children? Yes No
7. Does your child get along well with the family? Yes No
8. Is your child receiving special services at school? Yes No
9. Is your child receiving mental health services? Yes No
10. Has your child ever lived with a family beside his/her parents? Yes No

ENVIRONMENTAL HISTORY

1. Does your child live in a house built before 1960? Yes No
2. Does your child drink water that has fluoride in it? Yes No
3. Do you have guns in your house? Yes No
   If yes, are they locked up? Yes No
4. Does anyone in the house smoke? Yes No
5. Does your child attend daycare? Yes No
6. Has your child traveled outside of the USA? Yes No
7. Has your child been exposed to a person with tuberculosis? Yes No

FAMILY HISTORY

Mother's name ______________________________ Father's name ____________________________________
Age____Health? __________Years in school _____ Age_____ Health? ______________ Years in school ____
Stepmother's name ___________________________ Stepfather's name _________________________________
Age____Health? __________Years in school ______Age______Health? ______________Years in school ____
List names, ages, sex and general health of child's brothers and sisters:
____
____
Do any close family members (mother, father, grandmother, grandfather, brothers, sisters, aunts, uncles, nieces, nephews) have any of the following:

□ deafness before age 20	□ heart attacks before age 50	□ liver problems	□ alcoholism
□ allergies	□ high blood pressure	□ kidney disease	□ drug abuse
□ asthma	□ high cholesterol	□ diabetes in childhood	□ mental illness
□ anesthesia problems	□ anemia	□ bedwetting	□ mental retardation
□ tuberculosis	□ hemophilia	□ convulsions/epilepsy	□ immune problems, HIV/AIDS

HEALTHCARE HISTORY

Previous primary care physician: ____
Dentist: ____
Complementary care provider (chiropractor, acupuncturist, etc): _____________________

PARENTS' MAIN HEALTH CONCERNS FOR THIS CHILD: ____________________________
____
____