Integrative Pediatrics

Safe passage in a changing world.

PATIENT HEALTH HISTORY

Todays's Date _____

_____	_____	_____
Patient's Last First MI	**Age**	**Date of Birth**

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. How many hours did the labor last? _____ Hours
6. What was the birth weight? _____ lbs. _____ ozs.
7. Did your baby have any trouble starting to breath? NO □ YES □
8. 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. Does your child often have diarrhea? NO □ YES □
5. Has constipation ever been much of a problem? NO □ YES □
6. Does your child take any medicine? NO □ YES □
7. Has he/she had any allergies or reactions to any medicines or injections? NO □ YES □
8. Has he/she ever had eczema or hives? NO □ YES □
9. Has he/she ever had wheezing or asthma? NO □ YES □
10. Does he/she tend to have a stuffy nose or "constant cold"? NO □ YES □
11. Has your child had as many as three bouts of ear trouble? NO □ YES □
12. Does he/she have more than three colds or throat infections a year with fever? NO □ YES □
13. Does he/she hear well? NO □ YES □
14. Does he/she have any trouble passing urine? NO □ YES □
15. Has he/she ever had a convulsion or fit? NO □ YES □
16. Has he/she had any trouble with his/her eyes? NO □ YES □
17. Has he/she had any trouble with his/her teeth? NO □ YES □
18. Is there anything wrong with the way he or she walks? NO □ YES □
19. Check any of the following that your child has had:

☐ "Red or Hard" Measles ☐ Whooping Cough

☐ German or "3-Day" Measles ☐ Serious Accidents

☐ Broken Bones ☐ Pneumonia

☐ Removal of Adenoids and Tonsils

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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. Doe he/she get along well with other children? NO □ YES □
7. Check any of the following problems which your child has:

□ Wets Bed □ Nightmares □ Speech Problems
□ Won't Toilet Train □ Breath-Holding □ Destructive
□ Wetting During the Day □ Temper Tantrums □ Mean to Animals
□ 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:

□ Mental Retardation □ Diabetes □ Early Death
□ Mental Illness □ Heart Disease □ Inherited Diseases
□ Deformities □ High Blood Pressure □ Asthma
□ Seizures

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