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***Pediatric Health History Questionnaire  
Infant to five years of age***

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birth Gender (circle one): F M GN

Legal Parent or Guardian: \_\_\_\_\_  
*Father Mother Guardian*

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone # (home): \_\_\_\_\_ (work): \_\_\_\_\_

Parent Status: Married: \_\_\_ Separated: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_ Single: \_\_\_ Partnership: \_\_\_ Birth  
relative/ parent: \_\_\_ Adoptive Parent/ relative: \_\_\_

Child lives with (indicate siblings, extended family, parents, housemates, etc.): \_\_\_\_\_

Is this the child's only home? \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

**Emergency Contact:**

Next of Kin or other to reach in an emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**Health Care History**

Is your child receiving additional healthcare? Y N

If yes, name and address of doctor's office/ hospital/ clinic where your child's health records are kept: \_\_\_\_\_

If no, when and where did your child last receive medical or health care? \_\_\_\_\_

What was the reason? \_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES OF EACH PAGE**

What are your child's important health problems? List as many as you can in order of importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_

Does your child have any known contagious diseases at this time? Y N

If yes, what? \_\_\_\_\_

**Family History**

Do your child have a family history of any of the following (please circle)?

- |  |  |                                       |   |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Epilepsy       |
| <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Asthma/ hayfever/ hives |  |                                       |   |

Any other relevant family history? \_\_\_\_\_

What is your child's ethnic heritage and/or cultural upbringing: \_\_\_\_\_

Previous pregnancies by birth mother, miscarriages, or complications: \_\_\_\_\_

Mother's age at child's birth: \_\_\_\_\_

Mother's Health during pregnancy

- |   |                                       |  |   |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Bleeding                     | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Illness             | <input type="checkbox"/> Cigarettes     |
| <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Alcohol/ Drugs |
| <input type="checkbox"/> Physical or emotional trauma |                                       |  |   |

**Birth History/ Term**

- |                               |                                    |                               |                 |
|-------------------------------|------------------------------------|-------------------------------|-----------------|
| <input type="checkbox"/> Full | <input type="checkbox"/> Premature | <input type="checkbox"/> Late | Weight at Birth |
|-------------------------------|------------------------------------|-------------------------------|-----------------|

Length of labor: \_\_\_\_\_ Complications?  yes  no Explain: \_\_\_\_\_

**As a baby, did your child have any of the following?**

- |                                    |                                   |   |                                    |
|------------------------------------|-----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Birth Defects  | <input type="checkbox"/> Rashes    |
| <input type="checkbox"/> Colic     | <input type="checkbox"/> Fever    | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Blue Baby | <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Other     |

**Feeding**

Breast Fed      How long?       Formula       Cow milk

**Age began**

Solid foods \_\_\_\_\_ Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ First Words \_\_\_\_\_

**Medical History** (check all that are applicable)

- |   |  |  |                                 |
|---|--|--|---------------------------------|
| <input type="checkbox"/> Measles                            | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Bronchitis                            | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Chicken Pox                        | <input type="checkbox"/> Pneumonia     | <input type="checkbox"/> Rubella                               | <input type="checkbox"/> Mumps  |
| <input type="checkbox"/> Frequent colds                     | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Croup                                 | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Tonsillitis: how many times? _____ |  | <input type="checkbox"/> Ear infections: How many times? _____ |                                 |

**Immunizations**

- |                                  |                                |                                  |                                    |                                      |
|----------------------------------|--------------------------------|----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> MMR     | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Diphtheria  |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> DPT   | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Influenza | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Other:  |                                |                                  |                                    |                                      |

Any adverse reactions to immunizations (please specify)? \_\_\_\_\_  
\_\_\_\_\_

**Hospitalization, Surgery, Imaging**

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's has your child you had?

_____ year: _____	_____ year: _____
_____ year: _____	_____ year: _____
_____ year: _____	_____ year: _____

**Special Studies**

	<i>When</i>	<i>Where</i>	<i>Results</i>
<input type="checkbox"/> Electroencephalogram	_____	_____	_____
<input type="checkbox"/> Psychological evaluation	_____	_____	_____
<input type="checkbox"/> Hearing	_____	_____	_____
<input type="checkbox"/> Speech/ Language	_____	_____	_____

**Allergies**

My child is hypersensitive or allergic to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental or chemicals (cats, mold, dust etc)? \_\_\_\_\_

*Mountain Sage Medicine*

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**Current Medications** Does your child take any of these medications?

**Now= Medication currently being taken    Past= medication taken at one time or another**

	<u>Now</u>	<u>Past</u>		<u>Now</u>	<u>Past</u>
<i>Aspirin</i>	_____	_____	<i>Asthma meds</i>	_____	_____
<i>Tylenol</i>	_____	_____	<i>Decongestants</i>	_____	_____
<i>Inhalers</i>	_____	_____	<i>Ibuprofen</i>	_____	_____
<i>Antibiotics</i>	_____	_____	<i>Topical Steroids</i>	_____	_____
<i>Antihistamine</i>	_____	_____	<i>Other</i>	_____	_____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking? Indicate frequency and dose.

- |          |          |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

**Symptoms:** Please circle. Y= current P=significant in the past N= never

<i>Hives</i>	Y	P	N	<i>Burning of urine</i>	Y	P	N	<i>Bloody Urine</i>	Y	P	N
<i>Eczema</i>	Y	P	N	<i>Frequent urination</i>	Y	P	N	<i>Cries Easily</i>	Y	P	N
<i>Bleeding Gums</i>	Y	P	N	<i>Heart Murmur</i>	Y	P	N	<i>Nervous</i>	Y	P	N
<i>Nose Bleeds</i>	Y	P	N	<i>Vomiting Spells</i>	Y	P	N	<i>Sleep Problems</i>	Y	P	N
<i>Acne</i>	Y	P	N	<i>Anemia</i>	Y	P	N	<i>Night Sweats</i>	Y	P	N
<i>High Fever</i>	Y	P	N	<i>Stomach Aches</i>	Y	P	N	<i>Sensitive to light</i>	Y	P	N
<i>Chronic Rash</i>	Y	P	N	<i>Jaundice</i>	Y	P	N	<i>Breath/ body odor</i>	Y	P	N
<i>Hearing Loss</i>	Y	P	N	<i>Easy Bruising</i>	Y	P	N	<i>Motion/ car sickness</i>	Y	P	N
<i>Diarrhea</i>	Y	P	N	<i>Flat Feet</i>	Y	P	N	<i>No appetite</i>	Y	P	N
<i>Sore Throat</i>	Y	P	N	<i>Constipation</i>	Y	P	N	<i>Nightmares</i>	Y	P	N
<i>Gas</i>	Y	P	N	<i>Canker Sores</i>	Y	P	N	<i>Wheezing</i>	Y	P	N
<i>Joint Pain</i>	Y	P	N	<i>Cough</i>	Y	P	N	<i>Dizzy spells</i>	Y	P	N
<i>Hair Loss</i>	Y	P	N	<i>Frequent Headache</i>	Y	P	N	<i>Frequent colds</i>	Y	P	N
<i>Unusual fears</i>	Y	P	N	<i>Bleeding Tendency</i>	Y	P	N	<i>Excessive Fatigue</i>	Y	P	N

Any condition(s) not mentioned? \_\_\_\_\_

**Typical Food Intake:** Please describe your child's typical diet

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

Is there anything else you would like to add or comment on?

**Thank you for your time and effort. I look forward to providing you with the best possible care.**