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Pediatric Health History Questionnaire
Six years of age to adolescence

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: _____

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 |

Tonsillitis: how many times? _____

Ear infections: How many times? _____

Immunizations

- Measles Polio MMR Small Pox Diphtheria
- Mumps DPT Tetanus Influenza Chicken Pox
- 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 environmentals or chemicals (cats, mold, dust etc)? _____

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) _____

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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.