# CHILD PATIENT HEALTH HISTORY

**We appreciate you taking the time to complete this form. All information is confidential. This form will be kept in your child's file. Please Print.**

**CHIEF HEALTH CONCERNS**

What are the health concerns for your child at this time?

_____

_____

**MEDICAL HISTORY**

How would you describe your child's general state of health? Excellent Good Fair Poor

Has your child had any serious conditions, illnesses, injuries, and/or hospitalizations?

_____

Does your child have any allergies (medicines, environmental, foods)?

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____

_____

Please list any past prescription medications:

_____

Approximately how many times has your child been treated with antibiotics?_____

What screening tests has your child had? (blood, hearing, vision, etc.) Y N

_____

May we contact the physician to get a copy of those tests? Y N

Doctors Name: _____ Telephone: _____

Please indicate which immunizations your child has had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Hepatitis A
- ☐ "Flu"
- ☐ MMR (measles, mumps, rubella)
- ☐ Smallpox
- ☐ Haemophilus influenza B
- ☐ Tetanus booster
- ☐ Hepatitus B
- ☐ Polio
- ☐ Smallpox

Please indicate if any adverse reactions:

_____

**PRENATAL HEALTH**

What was the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown

Father Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at the child's birth? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during pregnancy:

Bleeding High blood pressure Nausea Vomiting

Diabetes Thyroid problems Physical or emotional trauma

Other _____

Did the mother use any of the following during the pregnancy:

Tobacco Alcohol Recreational drugs _____

Prescription/Over-the-counter medications _____

Supplements _____

**BIRTH HISTORY**

Term length: Full _____ Premature: _____wks Late: _____wks

Length of Labour:_____ Weight at birth:_____

Any complications? _____

Was the birth: Vaginal C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

Jaundice Rashes Seizures Birth injuries: _____

Birth defects: _____

Other: _____

**DIET**

How was your infant fed?

Breast fed. How long? _____

Formula. Milk/soy/other: _____

What foods were introduces before 6 months? (Please list approximate month as well)

_____

_____

6 - 12 months?

_____

_____

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

How many times a day does your child eat the following:

Wheat (breads, pastas, etc.) _____

Dairy (milk, cheese, yoghurt, etc.) _____

Eggs _____

Soy _____

**HEALTH AND DEVELOPMENT**

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern:

_____

How would you describe your child's behaviour and performance at school?

_____

**FAMILY HISTORY**

Do either of the parents have a chronic illness? Y N Please describe:

_____

**ENVIRONMENT**

Is the child in: school daycare home care other _____

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe:

_____

How would you describe the emotional climate of the child's home?

_____

Is there anything that you feel is important that has not been covered?

_____

_____