

# 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?

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## 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?

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

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

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Please list any past prescription medications:

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

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

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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
- Hepatitis 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
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What was the mother's age at the child's birth? \_\_\_\_\_

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown
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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 introduced 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?

\_\_\_\_\_

\_\_\_\_\_