Natural Health Clinic of Olympia • 3624 Ensign Rd. NE Suite B • Olympia, WA 98506 • 360-491-4131

Pediatric Health History Form

Name_____Date_____Date of Birth_____

Parent names_____

PRESENT CONCERNS:_____

MEDICATIONS AND SUPPLEMENTS:

Medication Dose (mg/pill) How many times per day

_____

_____

_____

_____

Allergies or reactions to medicines:_____

PREGNANCY AND BIRTH:
Please indicate any medical problems during pregnancy_____
_____

Place of birth_____

Delivery by: □ Vaginal birth □ Caesarian
Birth weight_____ Birth length_____
Gestational age at birth_____
Any medical problems in baby's newborn period_____

NUTRITION AND FEEDING:
Was your child breastfed? □ No □ Yes, how long?_____
Has your child had any unusual feeding/dietary problems? □ No □ Yes:specify_____
_____

What does your child eat for breakfast:_____
Lunch:_____Dinner:_____

Number of bowel movements per day:_____

SLEEP:
Hours per night_____Naps_____
Any sleep problems?_____

IMMUNIZATIONS/INFECTIOUS DISEASES:
Is your child up to date on immunizations? □ No □ Yes □ Not sure
Has your child had any of these illnesses: □ Chickenpox □ Measles □ Mumps □ Whooping cough □ Strep throat
□ Pneumonia □ Croup □ Ear infections □ Mononucleosis □ Meningitis

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Name_____Date of birth_____Date_____

EXPOSURE/HABITS:
Do any household members smoke? □ No □ Yes Is there violence in the home? □ No □ Yes
Screen (TV, computer, phone, video games) hours per day_____

REVIEW OF SYMPTOMS: Please check any current symptoms your child has on the list below

__Fevers/chills/excessive sweating
__Unexplained weight loss/gain
__Mouth breathing/snoring
__Bad breath
__Frequent runny nose
__Problems with teeth/gums
__Tires easily with exertion
__Shortness of breath
__Cough/wheeze
__Chest pain
__Loose stools/diarrhea
__Daily bowel movement
__Blood in stool
__Abdominal pain
__Bedwetting
__Muscle/joint pain
__Rashes
__Hay fever/itchy eyes
__Headaches
__Anxiety/stress
__Depression
__Learning disorder

PAST MEDICAL HISTORY: Please describe any major medical problems and their date
_____
_____

Hospitalizations/Operations (with dates):_____
Broken bones or severe sprains (with dates):_____

FAMILY HISTORY:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions

Alcoholism_____
Cancer, specify type _____
Heart attack_____
Depression/suicide_____
Diabetes_____
High cholesterol_____
High blood pressure_____
Stroke_____
Other _____
Other _____

SCHOOL/SOCIAL HISTORY:
Does your child attend school or preschool? □ No □ Yes
Current grade_____Name of school_____
Any concerns about school performance?_____
Any concerns about relationship with other students?_____
Sports/exercise: Type_____How often?_____How long?_____
What is your child's disposition?_____