DR. MANDI'S INTEGRATIVE PEDIATRICS

HEALTH HISTORY FORM

PERSONAL INFORMATION Date:_____

Patient Name: _____ DOB: _____ Male/Female

Form Completed By (include relation to patient):_____

What are your child's important health concerns? List in order of importance

_____

_____

_____

_____

BIRTH HISTORY

Pregnancy History

Maternal age at delivery:

Fertility treatments: Yes or No

Illnesses during pregnancy:

Stressors during pregnancy:

Medications during pregnancy (including herbs, vitamins and supplements)

Alcohol or smoking during pregnancy:

Complications during pregnancy:

Vaginal delivery or Cesarean section:

Total number of pregnancies:

How many miscarriages/abortions:

How many live births:

Full term pregnancy:

Was your baby born more than two weeks premature:

Was your baby born more than two weeks overdue:

Place of birth:

Any complications following birth requiring further observation or hospitalization:

Baby's birth weight:

PAST MEDICAL HISTORY

Has your child had any serious illnesses?

Has your child been hospitalized?

Has your child had any injuries/accidents/poisonings?

Has your child had any wheezing or asthma or allergic reactions including anaphylaxis?

MEDICATION/ALLERGY HISTORY

Does your child take any medications including vitamins/herbs/supplements?

Does your child have any allergies – drugs, foods, bee stings

IMMUNIZATIONS

Is your child immunized? Please list the dates and immunizations received:

_____

_____

_____

_____

NUTRITION

Was your child breast fed or formula fed?

How many cups of milk does your child drink daily?

How many cups of water does your child drink daily?

Does your child drink juice or soda?

Does your child eat processed/boxed foods or canned foods?

Does your child eat fruits and vegetables daily?

Any food allergies – casein/nuts/gluten?

Does your child eat refined sugar/fast food/foods with artifical colors or flavoring or preservatives?

Does your child eat foods/beverages with artificial sweeteners?

REVIEW OF SYSTEMS

Please circle if your child has any of the following problems or if you have any concerns:

Skin issues	Heart	Genitals	Convulsions
Eyes	Lungs	Joints	Headaches
Vision	Asthma	Spine	Coordination
Ears/Ear tags	Allergies	Arms	Balance
Ear infections	Sore throat	Coughs	
Hearing	Stomach	Legs	Sleep problems
Colds	Diarrhea	Weakness	School problems
Mouth	Constipation	Fatigue	Behavior problems
Teeth/gums	Kidney	Fainting	
Lymph nodes	Urine	Fever	

Please list all family members in the household

	Name	Age	Medical illness
Father			
Mother			
Siblings			

_____

Please list relatives who may have had the following illnesses:

Diabetes

High blood pressure

Heart disease

Seizures or Epilepsy

Asthma

Allergies

Cancer

Blood diseases

Tuberculosis

Learning problems

ADHD/ADD

ENVIRONMENTAL HISTORY

Do you use a water purifier

Age of your home

Type of heat – electric/gas/oil/wood burning fireplace

Live near – power lines/woods/industrial areas

Flooring at home – carpet/wood/rugs

Smokers at home or outside

Pets at home

Cleaners at home including detergents

Does your child use sunscreen

Carbon monoxide detector at home

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