DR. MANDI'S INTEGRATIVE PEDIATRICS, LLC

Health History Form

PERSONAL INFORMATION Date: _____

Patient Name: _____ DOB: _____ Male/Female

Form Completed By (include relation to patient):

_____

What is 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 artificial 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