



CONFIDENTIAL PEDIATRIC HEALTH HISTORY FORM

(To be completed by parent/guardian)

Child's Name: _____ Date: _____

Male: _____ Female: _____ Age: _____ Date Of Birth: _____

Home Address: _____
Number & Street

City

Prov

Postal Code

Parent's Name (s): _____

Home Phone: (____) _____ Work Phone: (____) _____

Email: _____

Would you like to receive our quarterly newsletter? Yes No

Please list all other health care providers.

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

1. _____
2. _____
3. _____
4. _____
5. _____

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

List any **Medications**, Herbs, Vitamins, etc. your child is taking and dose:

Medical History

How was your child’s health in the first year of life? Poor Fair Good Excellent

Has your child ever taken antibiotics? Yes No If yes, for how long and for what condition?

Please list any illnesses, injuries and hospitalizations your child has sustained:

Indicate which of the following your child has had:

<input type="checkbox"/>	Rubella (German Measles)	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Measles	<input type="checkbox"/>	Strep Throat
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Impetigo
<input type="checkbox"/>	Roseola	<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	

Indicate which immunizations your child has had:

<input type="checkbox"/>	DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/>	Prevnar
<input type="checkbox"/>	Tetanus Booster; When?	<input type="checkbox"/>	H1N1
<input type="checkbox"/>	MMR (measles, mumps, rubella)	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	HPV (Guardasil)	<input type="checkbox"/>	Meningococcal
<input type="checkbox"/>	Haemophilus Influenza B	<input type="checkbox"/>	Rotavirus
<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Influenza	<input type="checkbox"/>	

Did your child experience any adverse reactions to any of the above immunizations? If so, please list to which immunization and reaction.

Does your child have any allergies? Yes No If yes, please indicate to what. _____

Family History

If any blood relatives have had any of the following please circle.

Diabetes, hypoglycemia, heart disease, kidney disease, cancer, TB, allergies, bleeding disorders, glaucoma, seizures, mental illness, sickle cell anemia.

Grandparents: L=Living D=Deceased

Fathers Side

Grandmother: L/D Age: _____

Grandfather: L/D Age: _____

Mothers Side

Grandmother: L/D Age: _____

Grandfather: L/D Age: _____

Parents: L=Living D=Deceased

Father: L/D Age: _____

Mother: L/D Age: _____

List Brothers/Sisters and ages: Medical Problems: L=Living D=Deceased

B/S L/D	B/S L/D	B/S L/D	B/S L/D	B/S L/D	B/S L/D
Age: _____	Age: _____	Age: _____	Age: _____	Age: _____	Age: _____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Prenatal History

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

How was the health of the mother during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Yes No If yes, list what medical care she received: _____

Please indicate if the mother experienced any of the following during the pregnancy:

	Bleeding		Nausea
	Diabetes		Vomiting
	High Blood Pressure		Physical or Emotional Trauma
	Thyroid Problems		Other:

Please indicate if the mother used any of the following during pregnancy:

	Alcohol
	Tobacco
	Recreational drugs:
	Prescription Medications:
	Over-the-counter Medications:
	Supplements:
	Other:

Birth History

Type of Birth: Vaginal C-Section Induced Forceps Anesthesia used

Term Length: Full Premature: _____ wks Late: _____ wks

Length of Labour: _____ Weight at Birth: _____

Please list any complications during the birthing process: _____

Indicate if your child experienced any of the following at or shortly after birth:

	Jaundice		Birth Injuries:
	Rashes		Birth Defects:
	Seizures		Other:

Nutrition

How was your infant fed?

Breast Fed. How long? _____ Formula. Mild/Soy/Other: _____

Other: _____

Please indicate which foods were introduced before 6 months of age with approximate month. _____

6-12 months?

Did your child have colic? Yes No

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

What does your child typically eat for:

Breakfast?

Lunch?

Dinner?

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What does your child snack on? _____

What beverages does your child consume (including total quantity)? _____

Environment

Is your child in: School Daycare Home Care Other: _____

What are your child's favorite activities? _____

Does your child exercise regularly? Yes No If yes, how much and how often? _____

Does anyone in your child's household smoke? Yes No

Are there animals in the home? Yes No If yes, what kind? _____

How is the child's home heated? _____

List any toxins or other hazards your child is regularly exposed to:

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

How is your child's ability to concentrate and focus on tasks at home?

At school?

Parent/Guardian Signature

Date

Name, Please Print

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