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Pediatric Health Questionnaire

Today's Date: _____/_____/_____ BLOOD TYPE:_____

Patient Name: _____ Birth date: ____/____/____ Age:_____

Mother's Name_____ Father's Name_____

Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____Cellular_____Work:_____

Email: _____

Type of Health Insurance: PPO____ HMO____ Other_____

Height: _____ Weight: _____

Siblings, gender & Ages _____

List of those living in primary home_____

Paternal Family Medical Conditions / Diseases:

_____ Autoimmune
_____ Alcoholism or addictions
_____ Mental or emotional illness
_____ Depression
_____ Bipolar
_____ Anxiety
_____ Other:

____ Personality disorder
____ Epilepsy
____ Thyroid disease - goiter, nodules, low thyroid
____ Learning disabilities
_____ Psychosis
_____ Obsessive compulsive disorder
_____ ADHD

Psychotropic Medications:_____

Maternal Family Medical Conditions / Diseases

_____ Autoimmune
_____ Alcoholism or addictions
_____ Mental or emotional illness
_____ Depression
_____ Bipolar
_____ Anxiety
_____ ADHD
_____ Other:

____ Personality disorder
____ Epilepsy
____ Thyroid disease - goiter, nodules, low thyroid
____ Learning disabilities
_____ Psychosis
_____ Obsessive compulsive disorder

_____ Night Blindness?

Psychotropic Medications:_____

Amalgam Fillings: How many: When Placed:

Any amalgam fillings placed in mother during pregnancy or breast feeding?

Can your child swallow capsules yet?

Mother's age at delivery:

Was child born within 2 weeks of the due date:

Vaginal or C-Section:

Any complications with labor or delivery:

Birth weight:

Did the child have: **Breathing problems** **Infection** **Jaundice** **Feeding Problems**

Did baby go home with mother:

Breast fed/how long:

Vaccination history and describe and adverse reactions or changes in behavior after receiving:

Describe general development of your child to date:

Eating patterns:

Sleep patterns:

History of antibiotic use since birth:

Surgeries, tubes in ears:

Seizures: Age of onset, type, accompanied by fever, timing regarding illness, injuries or vaccinations:

_____

_____

Any regression in speech:

Current speech ability:

Schooling academics:

Disruptive antisocial behavior in public:

Learning disorders, delays:

Teacher comments/reactions

Describe general personality:

Hyper or hypoactive:

Favorite foods:

Most disliked foods:

List any laboratory studies undertaken and results:

List any Stomach problems, stool patterns, colic, diahrea, heartburn, constipation, etc.

List any special diets and the reaction/results:

_____

_____

_____

_____

_____

- Does child use artificial sweeteners? _____ Yes What type?_____ _____ No
- Carbonated beverages?_____ Yes How many per day? _____ _____ No
- Do you have any pets?_____ Yes Type? _____ _____ No
- Have you lived or traveled outside of the United States?
  If so, when and where?

Allergies: Please check all that apply

_____ Penicillin	_____ morphine	_____ dye allergies	_____ seasonal (pollen) allergies
_____ Codeine	_____ aspirin	_____ nitrate allergy	_____ no known allergies
_____ sulfa drugs	_____ food allergies	_____ pet allergies	_____ other: _____

Please describe the allergic reaction you experienced and when it occurred: _____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

_____ pain reliever
_____ aspirin
_____ acetaminophen (Tylenol®)
_____ ibuprofen (Motrin IB®)
_____ naproxen (Aleve®)
_____ ketoprofen (Orudis KT®)
_____ cough suppressant (Robitussin DM®)
_____ antihistamine (Benadryl, Chlor-Trimeton®)
_____ decongestant (Sudafed®)
____ combination products (cough & cold reliever, Triaminic DM®)
____ sleep aids (Excedrin PC®, Unisom®, Sominex®, Nytol®)
____ antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)
____ Laxatives / stool softener (Doxidan®, Correctol®)
____ Diet aids / weight loss products (Dexatrim®
____ antacids (Maalox®, Mylanta®)
____ acid blockers (Tagamet HB®, Pepcid C®, Zantac 75®)
____ others: _____

Nutritional / Natural Supplements: Please check the products you are using & list below

_____ vitamins (multiple or single vitamins, i.e. B complex, E, C, carotene)
_____ minerals (calcium, magnesium, chromium, colloidal minerals, single minerals)
_____ herbs (Ginseng, Ginkgo Biloba, Echinacea, herbal medicinal teas, tinctures, etc.)
_____ enzymes (digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
_____ nutrition / protein supplements (shark cartilage, protein powders, amino acids, fish oils)
_____ others (glucosamine, etc.): _____

Vitamin/Mineral Supplement Name Date Started Dosage

Describe eating habits including the times you usually eat: (include deserts)

Breakfast Lunch Dinner Type of Snacks

Crave any foods?

Current Prescription Medications:

Medication Name Reason for Taking? Strength Date Started

Dental History

How many Silver/Mercury Amalgams do you have? _____
Recent cavities, crowns, root canals? Describe:_____
History of any Gum Disease? Describe:_____

One more page to go…

Describe your problems that lead you to this consultation:

What are your goals with this consultation?

Please write down any specific questions you may have.

If possible, please bring in, fax or mail any recent lab work or other test results. Thank you!