HEALTH HISTORY – PEDIATRIC

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Date: _____
Child's First Name: _____
Last Name: _____
Age: _____ Birth date:_____ /_____ Gender: _____
Who is filling out this form? (name)
_____
Contact Information:
Name _____
Phone: (h): (_____)_____
Relationship to child:
_____
With whom does the child live?

Other Healthcare providers this child is seeing: (please give name, type of practitioner/specialist)
1. 2. 3.
Primary Problem:
_____
(this will be discussed in detail in your first visit)

Other health concerns, in order of importance to you:
1.
_____
_____

2._____
_____

3._____
_____

4._____
_____

Please list any previously diagnosed medical conditions and their treatments:

_____
_____

How would you rate your child's general state of health?
□ excellent □ good □ fair □ poor

Please indicate any injuries or hospitalizations, along with dates:
_____
_____

Which of the following illnesses has your child had? Check all that apply
□ rubella (German measles) □ roseola □ impetigo □ measles
□ scarlet fever □ chicken pox □ mononucleosis □ ear infections
□ whooping cough □ strep throat □ tonsillitis □ mumps
□ skin concerns (eg. Rashes)
if yes, please note if there were any complications to these illnesses:

Vaccination/Immunization Record: Check all that apply
□ DTAP
(diphtheria, pertussis, tetanus)
□ MMR
(measles, mumps, rubella)
□ Menigococcal C
(meningitis)
□ Polio
□ BCG
(Tuberculosis)
□ Hepatitis A
□ Hepatitis B
□ Haemophilus Influenza B
□ Pneumococcal Conjugate
(meningitis/pneumonia)
□ Gardasil/Cervarix
(HPV)
□ Varivax/Varilix
(chicken pox)
□ Flu vaccine
□ Other : _____

Did any of the vaccines cause an adverse reaction? (fever, rash, temperament changes etc.)

_____

_____

Does your child have any allergies (medicines, environmental, foods)?

_____

_____

Please list any current medications (prescription and over the counter) and reason for taking:

_____

_____

PRENATAL HISTORY

Prenatal Influences: □ Alcohol □ coffee □ cigarettes □ drugs □ stress
□ other

_____

_____

Mother's age at conception: ____ Father's Age at conception: ____
Were fertility interventions used? ____
Pregnancy health: did the mother experience any of the following:
□ High blood pressure □ Diabetes □ Emotional Trauma
□ Physical Trauma □ Major illnesses □ Excessive Bleeding
□ Nausea
□ Vomiting
□ Other:

_____

_____

What was the mother's emotional health like during pregnancy:

_____

_____

List all medications/supplements taken during pregnancy and labour:

_____

_____

LABOUR / BIRTH HISTORY

What type of delivery: □ Vaginal birth □ C-Section □ Hospital □ Home Birth

Term length: _____ weeks Duration of Labour:

_____

Was labour induced?: □ Y □ N

Were there difficulties during the labour?:

Interventions during Labour:

□ Antibiotics □ Epidural □ Episiotomy □ Forceps □ Suction □ Fentanyl

APGAR Score: 1 min: ____ 5 min: ____ Birth Weight: _____ Length:

_____

Did the child experience any of the following:

□ Jaundice □ Birth Injuries □ Rash □ Infection

□ Colic □ Feeding Difficulties □ Seizures □ Respiratory Distress

□ Congenital Conditions:

_____

□ Other complications/illnesses:

_____

Interventions used after birth: □ Vitamin K □ Silver Nitrate Drops

□ Other

_____

FAMILY HISTORY

Please indicate if there are any familial issues concerning heart health, high blood pressure, cancer, mental illnesses, thyroid problems, kidney disease, gastrointestinal diseases, arthritis, auto-immune conditions and any other relevant health information

_____

_____

_____

Family Ages

Father ____ Mother ____

Grandmother (Paternal) ____

Grandmother (Maternal) ____

Grandfather (Paternal) ____
Grandfather (Maternal) ____
Siblings ____

DIET / LIFESTYLE
Nutrition/Feeding:
Was the child breastfed?: □ Y □ N If yes, For how long?
_____
Was the child formula fed: □ Y □ N If yes, when was it started?
_____
Age at 1st solid food: _____ Any reactions:
_____
What were the 1st
foods? _____
Is the child: □ Vegan □ Vegetarian
□ Other
_____

Is your child a good eater?
_____

Has the child reacted to any foods? (rash, vomiting, etc...
_____
_____

DEVELOPMENT AND SOCIAL HISTORY
At what age did the child
Roll over: _____ Sit up: _____ Crawl: _____ Walk: _____
Teeth: _____ Talk: _____ Toilet train: _____
Is there anything that the child finds particularly stressful?
_____
Does the child exercise regularly? □ Y □ N Hours/day: _____
Type of exercise:
_____
Number of hours per day for: TV _____ Video Games _____
Computer _____

Is there any other important information or concerns that you would like to address in our visits?

_____

_____

How does the child interact with friends/family?

_____

_____