RegeneMed
200 E. Thruston Blvd.
Dayton, OH 45419
P:937.242.6132 / F:614.559.6737

Patient Name:_____
DOB:_____ Wt: _____ Ht: _____
Date Questionnaire Completed: _____

FORM 11: BRIEF PEDIATRIC QUESTIONNAIRE

Allergies:

Birth History: Birth Weight, Hospital stay.

Delivery: Natural vs. Cesarean. Maternal Illness during Pregnancy and Delivery. Maternal Antibiotics, vaccinations and other medications.

Breastfed? For how long exclusively? Formula, since when? Which? For how long? Age at first foods:

Order of Birth, Illness in siblings or similar symptoms

Vaccination History: Up to date? Any adverse reactions? Attach copy of vaccination card.

Past Surgeries, Hospitalizations, Trauma/Fractures and any other medical problems in the past

History of Antibiotic Use:

Present Diagnosed Medical Problems

Current Medical Treatment:

Vitamins, Herbs, other: Please list brand, dose, frequency:

History of Illness in the family (mom,dad, siblings, grandparents, first cousins, uncles/aunts)

History of Allergies or Gastrointestinal complaints:

History of behavioral problems, attention, sleep: describe.

Dental health: Last visit to dentist? Any cavities repaired? What kind of fillings were used?

Please list in order of importance all the concerns or problems that bring you to this visit. When did they start? Frequency? If past but significant, please add 'P' next to the number, on the left.

1	
2	
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8	

List here other concerns:

What brings you to this visit?

What do you expect to gain from any evaluation or treatment intervention that you complete with us?