SCIMEDICA
Advancing Medical Options

PEDIATRIC / ADOLESCENT HISTORY FORM

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

PATIENT'S FULL NAME _____ AGE ____ SEX ____ BIRTHDATE month/day/yr ____/____/____

NAME YOU PREFER TO BE CALLED _____ PARENT'S NAMES _____

ADDRESS _____ CITY _____ POSTAL CODE _____

HOME PHONE _____ PARENT'S WORK PHONE _____ (Mother, Father, Other)

FAMILY PHYSICIAN _____ SPECIALIST _____

CHIROPRACTOR _____ OTHER _____

WHO REFERRED YOU TO THIS OFFICE? _____

PRESENT HEALTH PROBLEMS: PLEASE LIST MOST IMPORTANT HEALTH CONCERNS / PROBLEMS

_____

_____

_____

MEDICATIONS:

	Now	Past	Frequency
ASPIRIN	___	___	_____
TYLENOL	___	___	_____
ANTIBIOTICS	___	___	_____
DECONGESTANTS	___	___	_____
_____	___	___	_____

SUPPLEMENTS:

	Now	Past	Frequency
VITAMINS	___	___	_____
MINERALS	___	___	_____
FLUORIDE	___	___	_____
HERBS	___	___	_____
_____	___	___	_____

ALLERGIES: (to medications, pollens, animals or food)

CHILDHOOD ILLNESSES:

___ CHICKEN POX
___ MEASLES
___ MUMPS
___ RUBELLA
___ SCARLET FEVER
___ RHEUMATIC FEVER
___ STREP THROAT
___ PNEUMONIA
___ MONONUCLEOSIS
___ EAR INFECTIONS
___ TONSILLITIS
___ OTHER _____

IMMUNIZATIONS: (age given, any adverse reactions?)

___ DPT (Diptheria, Pertussis, Tetanus)
___ MMR (Measles, Mumps, Rubella)
___ POLIO
___ HAEMOPHILUS INFLUENZA type B (Meningitis)
___ HEP-B (Hepatitis B)

PATIENT'S MEDICAL HISTORY:

	Now	Past	Never
ACNE	___	___	___
ALLERGIES	___	___	___
ANEMIA	___	___	___
ASTHMA	___	___	___
BED WETTING	___	___	___
BIRTH DEFECTS	___	___	___
COLIC	___	___	___
CONSTIPATION	___	___	___
COUGH/WHEEZE	___	___	___
CRADLE CAP	___	___	___
DEPRESSION	___	___	___
DIARRHEA	___	___	___
DIZZY SPELLS	___	___	___
EARACHES	___	___	___
ECZEMA	___	___	___

	Now	Past	Never
EPILEPSY/SEIZURES	___	___	___
FATIGUE	___	___	___
FREQUENT INFECTIONS	___	___	___
HEADACHES	___	___	___
HEART MURMUR	___	___	___
HIGH FEVER	___	___	___
HYPERACTIVITY	___	___	___
INSOMNIA	___	___	___
JAUNDICE	___	___	___
LEARNING DISORDER	___	___	___
MOODINESS	___	___	___
STUFFY NOSE	___	___	___
THRUSH	___	___	___
VOMITING SPELLS	___	___	___
OTHER _____	___	___	___

SURGERIES (YEAR & TYPE) _____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

_____

OTHER CONDITIONS _____

_____

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* _____ MOTHER (age)* _____ BROTHERS (ages)* _____ SISTERS (ages)* _____

* If deceased, Please list age at death and circle.

IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1, B2, S1, etc.).

___ ALCOHOLISM	___ BLEEDING DISORDER	___ HEART DISEASE	___ OBESITY
___ ALLERGIES	___ CANCER of _____	___ HEARING LOSS	___ STOMACH ULCERS
___ ANEMIA	___ COLITIS	___ HIGH BLOOD PRESSURE	___ STROKE
___ ARTHRITIS	___ DIABETES	___ HYPOGLYCEMIA	___ THYROID DISORDER
___ ASTHMA	___ ECZEMA	___ KIDNEY DISEASE	___ TUBERCULOSIS
___ BIRTH DEFECTS	___ EPILEPSY	___ MENTAL ILLNESS	___ OTHER _____

DOES PATIENT HAVE ANY OF THE ABOVE? _____

IF YES, WHICH ONES _____

PRENATAL / BIRTH / FEEDING HISTORY:

1. MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS PATIENT

___ AGE	___ TRAUMA/INJURY	___ ALCOHOL CONSUMPTION	___ OTHER _____
___ BLEEDING	___ STRESS	___ DRUGS	___ TOXEMIA
___ NAUSEA	___ HIGH BLOOD PRESSURE	___ SMOKING	
___ ILLNESS	___ X-RAYS	___ MEDICATIONS _____	

2. TERM ___ PREMATURE ___ FULL BIRTH WEIGHT _____

3. WAS PREGNANCY / BIRTH ___ EASY? ___ DIFFICULT? ___ C-SECTION?

4. FEEDING OF INFANT

BREAST FED _____	HOW LONG? _____	COW'S MILK? _____
FORMULA FED _____	HOW LONG? _____	TYPE OF FORMULA _____
AGE SOLID FOODS BEGUN _____		WHAT FOODS? _____
ANY FOOD ALLERGIES OR INTOLERANCES? _____		TO WHAT FOODS? _____

5. SAMPLE DAILY DIET (Choose a typical day and include food and liquids)

6. PREVIOUS PREGNANCIES BY NATURAL MOTHER AND ANY COMPLICATIONS

SOCIAL HISTORY:

1. PARENTS:	___ MARRIED	___ SEPARATED	___ DIVORCED
MOTHER'S OCCUPATION _____		___ FULL TIME	___ PART TIME
FATHER'S OCCUPATION _____		___ FULL TIME	___ PART TIME
2. OTHER GUARDIAN: _____			RELATIONSHIP _____
3. OTHERS RESIDING IN HOME _____			RELATIONSHIP _____
4. DAYCARE/PRESCHOOL/SCHOOL: HOW MANY HOURS EACH DAY? _____			# DAYS OF THE WEEK? _____
5. INTERACTION WITH RELATIVES: WHO? _____			HOW OFTEN? _____

DO YOU HAVE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS? PLEASE EXPLAIN.

_____

_____ SIGNATURE: _____