Wholesome Family Medicine
4036 S. 6th St. Ste. #2 Klamath Falls, OR 97603
Phone: (541) 851-9320 Fax: (541) 851-9322

Pediatric Patient Health History
Birth to Five Years of Age

Name: _____
Last *First* *M.I.*

Date of Birth: _____ **Age**: _____ **Gender: F M** _____

S.S.#: _____

Name and address of Dr's office/hospital/clinic where your child's health records are kept:

_____
Office/Hospital/Clinic Name *Street/ P.O. Box*

_____
City *State* *Zip Code*

Parent or Guardian: _____ _____ _____
Father *Mother* *Guardian*

Address: _____

City:_____ **State:** _____**Zip Code:**_____

Telephone: Please circle the preferred number to contact you:
Home #:_____Work #:_____Cell #:_____

E-mail:_____**S.S.#**: _____

Insurance Provider: _____

Verification of Naturopathic Coverage?:_____

How did you hear about Wholesome Family Medicine?: _____

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems?

1) _____ 3) _____

2) _____ 4) _____

MEDICATIONS

Any known drug allergies? If yes, please list drug and reaction: _____

_____

Now = medications currently being taken. Past =medications taken at one time or another

	Now	Past		Now	Past
Aspirin	____	____	*Asthma Medications*	____	____
Ibuprofen	____	____	*Decongestants*	____	____
Inhalers	____	____	*Topical Steroids*	____	____
Antibiotics	____	____	*Other*	_____	
Anti-histamine	____	____		_____	

MEDICAL HISTORY

Does your child have any allergies to foods, drugs or other allergens in your environment (cats, mold, dust)? Yes _____ No _____ If yes, list and explain. _____

_____

_____

Has your child ever had : (Check those that are applicable)

_____*Chicken pox*	____ *Scarlet fever*	____*Bronchitis*	____*Asthma*
_____ *Measles*	____ *Pneumonia*	____*Rubella*	____*Mumps*
_____*Frequent Colds*	____*Eczema*	____*Croup*	
_____*Tonsillitis-How many times?*		____*Ear infections-How many?*	____*Other*_____

X-RAYS AND SPECIAL STUDIES

	When	Where	Results
_____*Electroencephalogram:*			
____ *Psychological Evaluation:*			
____*Hearing:*			
____*Speech/Language:*			

INJURIES/SURGERIES/HOSPITALIZATIONS

_____

_____

_____

IMMUNIZATIONS

_____ *Varicella*	____*Polio*	_____*MMR*	_____*Rotavirus*	____*Hep B*
____*Mumps*	____*DTaP*	_____*Tetanus*	_____*Influenza*	____*Pneumococal*
___ *Hep A*	___ *HiB*	*Other:* _____		

Any adverse reactions to immunizations? (Please specify)

_____

_____

As a baby, did your child have any of the following problems?

____*Jaundice*	____*Diarrhea*	____*Birth defects*	____*Rashes*
____*Colic*	____*Fever*	____*Cerebral palsy*	____*Allergies*
____*Blue baby*	____*Seizures*	____*Birth injuries*	____*Other*_____

Feeding: ____*Breast fed* ____*How long?* ____*Formula: Milk or Soy*

Age Began: ____*Solid foods* ____*Sitting* ____*Crawling*
____*Walking* ____*First words*

SYMPTOMS

Please circle: Y=a condition your child has now N=never had P=has had in the past

Hives	Y P N	*Burning of urine*	Y P N	*Bloody urine*	Y P N
Eczema	Y P N	*Frequent urination*	Y P N	*Cries easily*	Y P N
Bleeding gums	Y P N	*Heart Murmur*	Y P N	*Nervous*	Y P N
Nose bleeds	Y P N	*Vomiting spells*	Y P N	*Sleep problems*	Y P N
Acne	Y P N	*Anemia*	Y P N	*Night sweats*	Y P N
High fever	Y P N	*Stomach aches*	Y P N	*Sensitive to light*	Y P N
Chronic rash	Y P N	*Jaundice*	Y P N	*Body/Breath odor*	Y P N
Hearing loss	Y P N	*Easy bruising*	Y P N	*Dental cavities*	Y P N
Diarrhea	Y P N	*Flat feet*	Y P N	*No appetite*	Y P N
Sore throats	Y P N	*Constipation*	Y P N	*Nightmares*	Y P N
Gas	Y P N	*Canker sores*	Y P N	*Wheezing*	Y P N
Joint pains	Y P N	*Cough*	Y P N	*Dizzy spells*	Y P N
Hair loss	Y P N	*Frequent Headaches*	Y P N	*Frequent colds*	Y P N
Unusual fears	Y P N	*Bleeding tendency*	Y P N	*Excessive fatigue*	Y P N

Does your child have any other condition not mentioned? _____
_____

DIET

Please describe your child's typical daily diet: _____
_____
_____
_____

Does your child have any food intolerance's that you know of? Yes _____ No _____
If yes, please explain: _____
_____

FAMILY HISTORY

____*Heart Disease* ____*Diabetes* ____*Birth defects* ____*Cancer* ____*Mental Illness*
____*Hypertension* ____*Arthritis* ____*Tuberculosis* ____*Allergies* ____*Hay fever*
____*Eczema* ____*Other (please explain)*_____
_____

BIRTH HISTORY

Previous pregnancies by natural mother, miscarriages or complications: _____
_____

Mother's age at child's birth: _____

Mother's health during pregnancy:
____*Bleeding* ____*Hypertension* ____*Illness* ____*Cigarettes, alcohol, drugs*
____*Nausea* ____*Diabetes* ____*Thyroid Problems*
____*Physical or emotional trauma*

Term:
____*Full* ____*Premature* ____*Late* _____*Weight at Birth*
____*Length of labor* *Complications?* _____*Yes* _____*No*