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
Six Years of Age to Eighteen

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)

____

____

SYMPTOMS

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

Condition		Condition		Condition	
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*	*motion/car sick*	*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 intolerances that you know of? Yes _______ No ________

If yes, please explain: ____

____

FAMILY HISTORY (Y or N)

____*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*