

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 Dr. Blevins?: _____

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
<i>Aspirin</i>	_____	_____	<i>Asthma Medications</i>	_____	_____
<i>Ibuprofen</i>	_____	_____	<i>Decongestants</i>	_____	_____
<i>Inhalers</i>	_____	_____	<i>Topical Steroids</i>	_____	_____
<i>Antibiotics</i>	_____	_____	<i>Other</i>	_____	_____
<i>Anti-histamine</i>	_____	_____		_____	_____

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)

- | | | | |
|--|---------------------------------------|-------------------------|---------------------|
| _____ <i>Chicken pox</i> | _____ <i>Scarlet fever</i> | _____ <i>Bronchitis</i> | _____ <i>Asthma</i> |
| _____ <i>Measles</i> | _____ <i>Pneumonia</i> | _____ <i>Rubella</i> | _____ <i>Mumps</i> |
| _____ <i>Frequent Colds</i> | _____ <i>Eczema</i> | _____ <i>Croup</i> | |
| _____ <i>Tonsillitis-How many times?</i> | _____ <i>Ear infections-How many?</i> | _____ <i>Other</i> | _____ |

X-RAYS AND SPECIAL STUDIES

When	Where	Results
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Electroencephalogram: _____

_____ *Psychological Evaluation:* _____

_____ *Hearing:* _____

_____ *Speech/Language:* _____

INJURIES/SURGERIES/HOSPITALIZATIONS

IMMUNIZATIONS

- | | | | | |
|------------------------|--------------------|----------------------|------------------------|---------------------------|
| _____ <i>Varicella</i> | _____ <i>Polio</i> | _____ <i>MMR</i> | _____ <i>Rotavirus</i> | _____ <i>Hep B</i> |
| _____ <i>Mumps</i> | _____ <i>DTaP</i> | _____ <i>Tetanus</i> | _____ <i>Influenza</i> | _____ <i>Pneumococcal</i> |
| _____ <i>Hep A</i> | _____ <i>HiB</i> | <i>Other:</i> _____ | | |

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		
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