

HEALTH HISTORY-PEDIATRIC

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Date: _____

Name: (Surname)_____ (First name)_____

Formed Completed By: (Name)_____

(Relation to Child)_____

Gender (circle): M / F

Date of Birth:

(Month)_____ (Day)_____ (Year)_____

Birthplace: (Country)_____

Address:

(Province/ State)_____

(Postal Code)_____

Phone Number:

Home: (_____)_____

Parent at Work: (_____)_____

Parent Cell: (_____)_____

Family Email: _____

Which of the above do you give permission for our office to contact you at? (circle above)

Emergency Contacts:

1) Name: (Surname)_____ (First Name)_____

Telephone: (_____)_____

(Relation to Child)_____

2) Name: (Surname)_____ (First Name)_____

Telephone: (_____)_____

(Relation to Child)_____

Child Lives With:

Ethnicity:_____

Pediatrician / Family Medical Doctor:

(Name)_____

(Address)_____

(Telephone)_____

(Fax)_____

Other Health Care Professionals:_____

Reasons for Seeking Care (please list in order of importance to you):

1. _____
2. _____
3. _____
4. _____
5. _____

Childhood Illnesses (circle):

Measles / Mumps / Rubella / Chickenpox / Whooping Cough /
Strep Throat / Roseola / Scarlet Fever / Strep Throat / Mononucleosis
/ Ear Infection / Other: _____

Accident(s) / Injuries (circle):

Automobile accident / Fracure / Break / Penetrating Wounds /
Head Injury / Burns /
Other: (Describe / Dates): _____

History of Serious or Chronic Illness

(Describe) _____

Hospitalization(s): (Cause / Name of Hospital / Treatment Received /
Date and Duration of Hospitalization/ Name of Physician):

Operation(s): (Type of Surgery / Date of Surgery / Name of Surgeon /
Name of Hostpital / Recovery): _____

Current Medications:

Drug Name	Dose	Frequency	Date /Onset	Discontinued

Allergies: (Medication / Food / Environmental / Plant / Animal/Insect/
Vaccine reaction)

Immunizations:

Immunization	Date
Measles – Mumps – Rubella	
Polio	
Diphtheria – Pertussis – Tetanus	
Hepatitis B	
Hepatitis A	
Haemophilus Influenzae Type B	
Pneumococcal Vaccine	
Varicella	
Tetanus Booster	

Last Examination Dates:

Examination	Date
Physical	
Dental	
Vision	
Hearing	
Other	

Family Health History:

Do any of the following health conditions affect your family members?

Condition	Presence in Family	Relative affected
<i>Heart Disease</i>		
<i>High Blood Pressure</i>		
<i>Stroke</i>		
<i>Diabetes</i>		
<i>Blood Disorder</i>		
<i>Sudden Infant Death</i>		
<i>Birth Defects</i>		
<i>Learning Disabilities</i>		
<i>Mental Disabilities</i>		
<i>Cystic Fibrosis</i>		
<i>Sickle Cell Anemia</i>		
<i>Cancer</i>		

Tuberculosis		
Arthritis		
Allergies		
Obesity		
Alcoholism		
Mental Illness		
Seizure Disorder		
Kidney Disease		
Other		

Prenatal Health *(Parental health before birth of child)*

Father's Health

Mother's Health

Mother's Diet: _____

Mother's Age at birth of child: _____

Father's Age at birth of child: _____

Mother received prenatal medical care?: *(circle)* Yes / No

Pregnancy-Mother experience any of the following?: *(circle)*

Bleeding / Hypertension / Severe Nausea & Vomiting / Diabetes /

Thyroid Disorder / Physical or Emotional Trauma / Exercise /

Strong Food Cravings / Other: _____

Maternal Exposures / Stresses during Pregnancy?: *(circle)*

Tobacco / Alcohol / Recreational Drugs / Prescription Medication /

Over-The-Counter-Medication / Occupational Exposures / Caffeine /

Second hand smoke / Supplements /

(Other/Describe): _____

Length of Pregnancy: *(Number of Weeks):* _____

APGAR Score: _____

Length of Labor: *(Number of Hours):* _____

Birth Weight: _____ **Birth Height:** _____

Circumstances / Interventions During Labor / Childbirth: *(circle)*

Vaginal Birth / Forceps / Suction / C-Section / Anesthesia /

Induced Labor / Epidural /

Other: _____

Neonatal Complications: *Such as jaundice, seizures, birth injuries, congenital abnormalities...*

(Describe): _____

Was Your Infant Fed Breastmilk? Yes / No **How Long?:** _____

Was Your Infant Fed Formula? Yes / No **Name / Types?:** _____ **How Long?:** _____

What foods were introduced before 6 months? _____

What foods were introduced between 6 -12 months? _____

Milestones: (Age achieved)

Sitting Up: _____ Crawling: _____ Walking: _____

First Tooth: _____ Talking: _____

Toilet Trained: _____

Current Weight/Height:(Gain/Loss over period of time – cause) _____

Is your child experiencing any of the following symptoms? (circle)

Fatigue / Weakness / Fever / Chills / Sweating / Night Sweats

If your child is currently experiencing or has frequently experienced any of the following, place a checkmark in the corresponding box:

Y = Currently experiencing N= Never experienced P = Experienced

frequently in Past

Skin/Hair/Nails	Assessment			Comments
Skin Disease	Y	N	P	_____
Skin Rashes / Lesions	Y	N	P	_____
Skin Pigment Change	Y	N	P	_____
Change in Mole	Y	N	P	_____
Excessive Itching	Y	N	P	_____
Excessive Bruising	Y	N	P	_____
Excessive Dryness	Y	N	P	_____
Excessively Moist	Y	N	P	_____
Excessive Hair Loss	Y	N	P	_____
Excessive Hair Growth	Y	N	P	_____
Hair Texture Change	Y	N	P	_____
Nail Changes	Y	N	P	_____

Head	Assessment			Comments
Head Injury	Y	N	P	_____

Vertigo / Dizziness	Y	N	P	_____
Headache / Migraine	Y	N	P	_____

Nose & Sinuses	Assessment			Comments
Nosebleeds	Y	N	P	_____
Sinusitis	Y	N	P	_____
Nasal Congestion	Y	N	P	_____
Nasal Polyps	Y	N	P	_____
Frequent Colds	Y	N	P	_____
Sense of Smell Change	Y	N	P	_____

Eyes & Ears	Assessment			Comments
Vision Changes	Y	N	P	_____
Corrective Lenses	Y	N	P	_____
Eye Disease	Y	N	P	_____
Eye Pain	Y	N	P	_____
Eye Discharge	Y	N	P	_____
Eye Red/ Swelling	Y	N	P	_____
Hearing Loss	Y	N	P	_____
Ear Pain / Infection	Y	N	P	_____
Tinnitus (Ear Ringing)	Y	N	P	_____

Mouth & Throat	Assessment			Comments
Mouth or Tongue				
Pain / Lesion	Y	N	P	_____
Frequent Sore Throat	Y	N	P	_____
Gum Disease	Y	N	P	_____
Toothache	Y	N	P	_____
Swallowing Difficulty	Y	N	P	_____
Hoarseness	Y	N	P	_____
Tonsillitis/ectomy	Y	N	P	_____
Taste Sense Altered	Y	N	P	_____
Neck Pain	Y	N	P	_____
Neck Restricted Motion	Y	N	P	_____
Neck Swelling	Y	N	P	_____
Lymph Nodes Enlarged	Y	N	P	_____

Chest	Assessment			Comments
Lung Disease	Y	N	P	_____
Bronchitis	Y	N	P	_____
Pneumonia	Y	N	P	_____
Shortness of Breath	Y	N	P	_____
Pain on Breathing	Y	N	P	_____
Cough	Y	N	P	_____
Chest Pain	Y	N	P	_____

Gastrointestinal	Assessment			Comments
Appetite Change	Y	N	P	_____
Food Intolerance	Y	N	P	_____
Abdominal Pain	Y	N	P	_____
Nausea / Vomiting	Y	N	P	_____
Gastrointestinal Disease	Y	N	P	_____
Constipation	Y	N	P	_____
Diarrhea	Y	N	P	_____
Rectal Condition	Y	N	P	_____

Urinary Tract	Assessment			Comments
Pain on Urination	Y	N	P	_____
Increased Frequency	Y	N	P	_____
Frequency at Night	Y	N	P	_____
Incontinence/Bedwetting	Y	N	P	_____
Bladder Infections	Y	N	P	_____
Kidney Infections	Y	N	P	_____
Blood in Urine	Y	N	P	_____
Urgency	Y	N	P	_____
Hesitancy	Y	N	P	_____

Musculoskeletal	Assessment			Comments
Muscle Pain/Cramps	Y	N	P	_____
Joint Pain /Swelling	Y	N	P	_____
Juvenile Arthritis	Y	N	P	_____

Neurological	Assessment			Comments
Fainting	Y	N	P	_____
Seizures/Convulsions	Y	N	P	_____
Paralysis	Y	N	P	_____
Muscle Weakness	Y	N	P	_____
Numbness/Tingling	Y	N	P	_____
Involuntary Movement	Y	N	P	_____
Loss of Balance	Y	N	P	_____
Speech Problems	Y	N	P	_____

Endocrine	Assessment			Comments
Heat or cold intolerant	Y	N	P	_____
Hormone Therapy	Y	N	P	_____
Excess Thirst/Hunger	Y	N	P	_____
Excessive Urination	Y	N	P	_____
Excessive Sweating	Y	N	P	_____
Diabetes	Y	N	P	_____
Hypoglycemia	Y	N	P	_____

Immune/Blood	Assessment			Comments
Anemia	Y	N	P	_____
Easy to Bleed/Bruise	Y	N	P	_____
Past blood transfusion	Y	N	P	_____
Lymph node swelling	Y	N	P	_____
Infectious Disease	Y	N	P	_____

Mental /Emotional	Assessment			Comments
Depression	Y	N	P	_____
Anxiety	Y	N	P	_____
Mood Swings	Y	N	P	_____
Bipolar Disorder	Y	N	P	_____
Tension /Stress	Y	N	P	_____
Phobias	Y	N	P	_____
Insomnia	Y	N	P	_____
Eating Disorder	Y	N	P	_____
Other				_____
Describe the Emotional Climate of your Home: _____				

Female Reproductive	Assessment			Comments
Regular Cycle	Y	N	P	_____
Painful Menstruation	Y	N	P	_____
Excessive Flow	Y	N	P	_____
PMS	Y	N	P	_____
Birth Control	Y	N	P	_____
Sexually Active	Y	N	P	_____
Pelvic Inflamm.Disease	Y	N	P	_____
PCOS	Y	N	P	_____
Endometriosis	Y	N	P	_____
Uterine Fibroids	Y	N	P	_____
Sexual Difficulties	Y	N	P	_____
Vaginal Itching	Y	N	P	_____
Vaginal Discharge	Y	N	P	_____
STD History	Y	N	P	_____
Cervical Dysplasia	Y	N	P	_____
Yeast Infections	Y	N	P	_____
Age of first period				_____
Date of last PAP				_____

Male Reproductive	Assessment			Comments
Sexually Active	Y	N	P	_____
Sexual Difficulties	Y	N	P	_____

Erectile Dysfunction	Y	N	P	_____
Testicular/Penile Pain	Y	N	P	_____
Testicular Mass	Y	N	P	_____
STD	Y	N	P	_____
Discharge /Lesions	Y	N	P	_____
Hernias	Y	N	P	_____

Nutrition

Dietary Restrictions: (Religious / Vegetarian / Vegan / Other)_____

Food Allergies / Sensitivities: _____

Describe a Typical Day's Diet: (Include Time of Day)

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages: (Include quantity)_____

What type of water does your child drink?_____

How many glasses of water per day you're your child drink?_____

Does your child eat dairy regularly? (circle) Y / N

Does your eat wheat regularly? (circle) Y / N

Do your child eat products containing refined sugar regularly? Y / N

How many cups of soda does your child drink per week?_____

How many times per week does your child eat red meat?_____

How many times per day does your child eat fruit?_____

How many times per day does your child eat vegetables?_____

Does your child eat organic food?_____

How often does your child eat out (food prepared outside of home)?_____

What food does your child crave?_____

Lifestyle/ Habits

How many hours of sleep does your child get?_____

At what hour does your child retire / rise to and from sleep?_____

Does your child wake rested? (circle) Y / N

Does your child exercise regularly? (circle) Y / N Describe:_____

How is your child's energy level (on a scale of 1-10, 10 being the highest):_____

How is your child's stress level (on a scale of 1-10, 10 being the highest):_____

Does your enjoy school: (circle) Y / N

Does your child have difficulty in school (describe):_____

Do your child take vacations regularly: (circle) Y / N

How does your child relax? (Television / Reading/ Other leisure activities):

Adolescent

Do you use recreational drugs? (circle) Y / N Describe (drug / frequency of use): _____

Do you smoke cigarettes/cigars/pipe/chewing tobacco? (circle) Y / N / Past

How many cigarettes smoked per day? _____

How many years did you smoke?_____

When was your last drink of alcohol?_____

How much did you drink at that time?_____

Out of the last 30 days, about how many days would you say that you drank alcohol?_____

Interpersonal Relationships / Resources

How does your child get along with family / teachers/ care-givers / friends?

Describe your child's support system:

To whom would your child go for support with a problem at school, with or a personal problem?_____

Coping / Stress Management:

Kinds of stresses in life in last year:_____

Change in lifestyle / current stress:_____

Methods to try and relieve stress (success): _____

List the five most stressful events in you child's life. Do these continue to affect? _____

Environmental Health

Do you have pets in the home? _____

Is the smoking in the home? _____

How is your home heated? _____