

Osteopathic Treatment and Family Medicine Office

Health History Questionnaire- (Pediatric, Age 0 to 18 years old) Please help us provide your child with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be absolutely confidential. If you have any questions or need clarification, please ask us. Thank You.

Child's Name: _____ Age: _____ Sex: F M Date: _____

Birthday: _____ Home: _____ Email: _____

Address: _____
(street) (city) (State) (Zip Code)

Mother's Name _____ Father's Name _____

In EMERGENCY, notify: _____ Phone: _____

Family physician/pediatrician: _____ Phone: _____

Who referred you to this office? _____

Has your child received care from an osteopathic physician or received an osteopathic treatment in the past? __ No __ Yes

If yes, details _____

With what main problem would you like us to help your child?

Please be as specific as you can about when the problem began and the extent it interferes with your child's daily activities:

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment, if any, have you tried in the past? Has it helped?

Any recent travel outside of the country? __ No __ Yes Details: _____

Any sick contacts within the past few weeks? __ No __ Yes Details: _____

Past Medical History:

asthma seizure history heart disease kidney disease allergies
 cancer ADD/ADHD autism cerebral palsy pneumonia
 skin disorder rheumatic fever thyroid disease meningitis diabetes
 reflux/GERD stroke hepatitis tuberculosis
 anemia/blood disorder high blood pressure other: _____
 fracture(s) or other trauma (auto accidents, falls, head injuries, etc); details: _____

_____ previous hospitalizations; details: _____

Child Name: _____

Did you choose to immunize your child? Yes No if so, is your child up-to-date on his/her vaccinations? Yes No Comments: _____

Birth History:

Gestation: Early; number of weeks _____ On time Late; number of weeks _____

Delivery: Length of labor _____ hours Normal, spontaneous vaginal delivery
 Forceps delivery Vacuum extraction Induced
 C-section; reason: _____

Medicine (if any) used to start or augment labor, or for pain: _____

Complications (gestational diabetes, high blood pressure, early labor, pre-eclampsia, jaundice, etc.): _____

Diet History:

Breastfeeding OR Formula (name: _____) Frequency: _____

Table-foods (please describe a typical day's diet):

Breakfast	Lunch	Dinner	Snack(s)
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Past Surgical History:

Tonsillectomy Appendectomy Hernia, repair, location: _____
 other, details: _____

Dental history:

Extractions Braces Head gear Root canal Reconstructive surgery

Development:

Age when child was able to: situp _____ crawl _____ walk _____ vocabulary (how many words now?) _____

Drug allergies:

None Or Specific drug allergies; please list name of medication(s) and reaction, if known: _____

Current medications:

My child does not take any medication on a regular basis

My child takes the following medications occasionally-please list specific medication(s): _____

My child takes the following medications on a regular basis-please list specific medication(s): _____

Family History:

Please check the appropriate box to indicate specific illnesses for each family member as requested, if known):

	Living? Yes/No	Age	Allergies	Asthma/C OPD	Cancer, type	Diabetes	Heart disease	High blood pressure	Seizure	Stroke	Other (describe)
Father											
Mother											
Maternal grandmother											
Maternal grandfather											
Paternal grandmother											
Paternal grandfather											
Brother											
Brother											
Sister											
Sister											

Social History:

Child lives with: _____

Pets in the home: NO YES; please describe: _____

Exercise (type, frequency): _____

Current school/day-care: _____

Safety concerns (smoke detector in home? Car seat/seatbelts? Exposure to swimming pools or bodies of water? Bicycle safety/helmets? Response to strangers? Peer pressure? Etc.) _____

Any exposure to tobacco, alcohol, "street" drugs? _____

Hobbies: _____

System Reviews: Has your child experienced any of the following (see below) within the past few weeks?

General:

Fever Chills Night sweats Appetite changes Sleeping changes Weight gain/loss

Skin/Hair:

Rashes Eczema Ulceration Loss of hair Change in moles/new moles Changes in skin texture
 Any other problems? _____

Head, Eyes, Ears, Nose and throat:

Dizziness Ringing in ears Change in hearing Ear pain Nose bleed
 Cataracts/Glaucoma Eye pain Glasses Change in vision Sore throat
 Headache/migraines Grinding teeth/jaw licks

Last optometry exam: _____ Last dental exam: _____

Any other problems? _____

Cardiovascular:

High blood pressure Low blood pressure Chest pain Fainting Irregular heartbeat
 Blood clots Dizziness/lightheadedness Phlebitis Difficulty breathing with activity
 Cold hand/feet Any other heart or blood vessel problems? _____

Respiratory:

Cough Coughing up blood Asthma Bronchitis Pneumonia Pain with deep breath
 Difficulty breathing when lying down Production of phlegm; what color: _____
 Any other lung problems? _____

Gastrointestinal:

Nausea Vomiting Diarrhea Constipation Bloating/belching/indigestion
 Black stools Blood in stools Rectal pain Bad breath Hemorrhoids
 Abdominal pain/cramps Difficulty swallowing Vomiting blood
 Any other problems with stomach or intestines? _____

Genitourinary:

Pain on urination Frequent urination Blood in urine Urgency to urinate Hesitancy
 Unable to hold urine Kidney stones Decrease in flow Sores on genitals Impotence
 Number of night-time awakening to urinate _____ Any particular color to your urine? _____
 Any other genital or urinary problems? _____

Musculoskeletal:

Neck pain Muscle pain Knee pain Muscle weakness Foot/ankle pain
 Hip pain Shoulder pain Hand/wrist pain Joint stiffness/pain
 Back pain; where? _____
 Any other joint or bone problems? _____

Neuropsychological:

Seizure Dizziness Areas of numbness Localized weakness Loss of balance/poor balance
 Anxiety Concussion Poor memory Lack of coordination Easily susceptible to stress
 Depression Has your child ever been treated for emotional problems? _____
 Has your child ever lost consciousness?(please describe details) _____
 Any other neurological or psychological problems? _____

Hematologic:

Easy bruising Easy bleeding Prolonged bleeding Any other hematologic problems? _____

Endocrine:

Strong thirst Large volume of urine Hair loss/growth Weight change Sleeping changes
 Any other endocrine (thyroid, pituitary, pancreas, adrenals, etc.) problems? _____

Gynecologic (female patient only):

Age at first menses _____ Date of last menstrual period _____
 Length of menstrual cycle (amount of time between each period) _____ days Regular/Irregular periods
 Length of menses (bleeding) _____ days Unusual character of bleeding/clots Painful periods
 Number of pregnancies _____ Miscarriages/Abortions _____ Number of births
 Vaginal discharge/sore Change in body/psyche prior to period
 Last PAP smear (date and results): _____
 Breast lumps Nipple discharge or bleeding
 History of STD (sexual transmitted disease)? YES NO Details _____
 Does your child practice birth control? _____ if so, what type and for how long? _____
 Any other gynecologic problems? _____