1821 Wilshire Blvd, Suite 500
Santa Monica, CA 90403
P 424-238-5003

Osteopathic Treatment and Family Medicine Office (Pediatric)

Health History Questionnaire – (Pediatric 0-18 Years Old)

Please help us provide you 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 questions or need clarification about the information requested, please ask us. Thank you.

Name: _____ Sex: F M Birthdate: _____ Age: _____ Date: _____
(Child: First/Last)

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Parent Email: _____

Parent Name: _____ Parent Cell Phone: _____

Parent Name: _____ Parent Cell Phone: _____

In EMERGENCY, notify: _____ Phone: _____

Relationship to patient: _____

Family Physician: _____ Phone: _____

Who referred you? _____

****

Main Problem: What would you like us to help you with?_____

_____

_____

_____

When did this problem begin (be specific): _____

_____

To what extent does this problem interfere with your child's daily activities? _____

_____

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Patient's Name: _____

What diagnosis and/or treatments have been given? _____

_____

_____

Past Medical History (please include dates): _____

_____

_____

Significant Illness:

☐ Anemia/blood disorder	☐ Asthma ☐ Cancer	☐ Diabetes	☐ Hepatitis
☐ High Blood Pressure	☐ Thyroid Disease	☐ Rheumatic Fever	☐ Pneumonia
☐ Thyroid disease	☐ Reflux/GERD/Peptic ulcer		☐ Cerebral palsy
☐ Heart Disease	☐ Tuberculosis	☐ Rheumatic fever	☐ Seizure
☐ Autism	☐ Pneumonia	☐ Meningitis	☐ Skin Disorder
☐ Hepatitis	☐ ADD/ADHD		

☐ Previous hospitalizations; details: _____

_____

Do you get immunizations? ☐ Yes ☐ No If so, are your immunizations up-to-date? ☐ Yes ☐ No

Last Td (tetanus) vaccine: _____ Last flu shot: _____

Last pneumococcal (pneumonia) vaccine _____ Others: _____

Diet History (please describe a typical day's diet):

Breakfast	*Lunch*	*Dinner*	*Snack(s)*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you or have you ever been on a restricted diet? ☐ No ☐ Yes, please describe: _____

Please tell us about your feeding habits: breast/bottle, solids, finger foods, amounts/frequency of feeding, likes and dislikes, and any reactions you may have noticed to particular foods (such as rashes, etc.)

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Patient's Name: _____

Dental history:

☐ Extractions ☐ Braces/Head gear ☐ Root canal ☐ Reconstructive surgery ☐ Crowns ☐ Appliances

☐ Other _____

Drug allergies:

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

_____

Current medications (please include vitamins, supplements, herbs, over-the-counter, prescriptions, etc.):

☐ I do not take any medications on a regular basis (but recently took magnesium for 20 days)

☐ I take the following medications occasionally--please list specific medication(s): _____

_____

☐ I take 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 if known):

	Living? Yes/No		Age	Allergies	Asthma /COPD	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:

Living situation: _____

_____

Exercise (type, frequency): _____

_____

Current occupation stressful? ☐ Yes ☐ No Please describe stressors (chemical, physical, psychological, etc.)

_____

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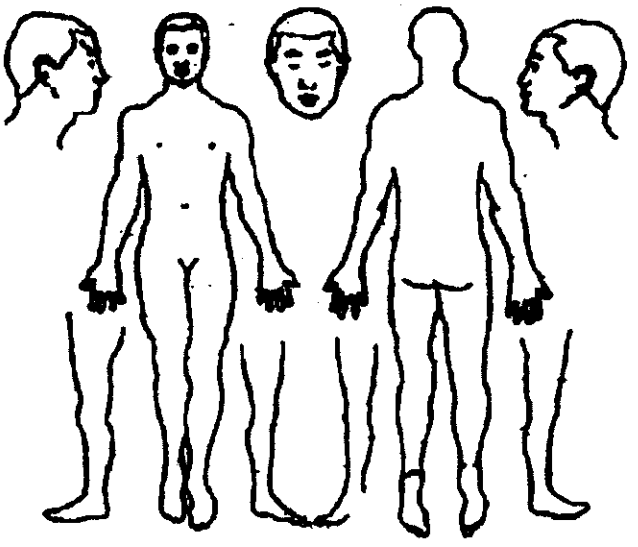
Habits: ☐ Cigarette/tobacco ☐ Coffee ☐ Tea ☐ Cola ☐ Salt
☐ Alcohol ☐ Sugar ☐ Drugs ☐ Other: _____

Hobbies/Relaxation techniques used: _____

Please indicate painful or distressed areas of your body using the diagrams below:



Systems Review: Have you experienced any of the following (see below) within the past few weeks?

General:
☐ Fevers ☐ Chills ☐ Night sweats/sweat easily ☐ Appetite changes ☐ Sleep changes/insomnia ☐ Fatigue
☐ Weight gain/loss ☐ Cravings ☐ Peculiar tastes or smells ☐ Sudden energy drop (time of the day?) _____

Skin/Hair:
☐ Rashes ☐ Eczema ☐ Ulceration ☐ Loss of hair ☐ Change in moles/new moles ☐ Change in skin texture
☐ Itching ☐ Dandruff ☐ Hives ☐ Acne/pimples ☐ Change in hair texture
☐ Any other problems? _____

Head, Eyes, Ears, Nose, and Throat:
☐ Dizziness ☐ Ringing in ears ☐ Change In hearing ☐ Ear pain ☐ Nose bleeds
☐ Cataracts ☐ Eye pain/Glaucoma ☐ Glasses ☐ Change in vision ☐ Sore throat
☐ Eye strain ☐ Color-blindness ☐ Night blindness ☐ Spots in front of eyes ☐ Jaw clicks/pain
☐ Teeth problems ☐ Grinding teeth ☐ Allergies/Sinus problems ☐ Headaches/migraines*
☐ Last optometry exam: _____ ☐ Last dental exam: _____

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*Please tell us about your headaches, including: location of pain, whether or not it travels/radiates, or stays in the same Place; does it come-and-go, or is it constant? What kind of pain is it - sharp, cramping, dull ache, pressure, stabbing, Hot/burning, other? Original injury (if known)? For how long have you been having headaches? What you are doing when the headaches start? How long do they last? What makes them better/worse? _____
_____
_____
_____

☐ Other head/eyes/ears/nose/throat problems: _____

Cardiovascular:

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Fainting ☐ Irregular heart beat
☐ Blood clots ☐ Dizziness/light-headedness ☐ Phlebitis ☐ Cold hands/feet ☐ Difficulty breathing
☐ Swelling of hands ☐ Swelling of 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 awakenings to urinate ☐ Any particular color to your urine? _____
☐ Any other genital or urinary problems? _____

Pregnancy and Gynecologic (Female Patients Only):

☐ Age at first menses _____ ☐ Date of last menstrual period _____ ☐ Regular/Irregular
Length of menstrual cycle (amount of time between each period) _____days Length of period _____days
☐ Unusual character of bleeding (heavy/light flow/clots) ☐ Painful periods ☐ Painful intercourse
☐ Vaginal discharge/sores ☐ Change in body/psyche prior to period ☐ Breast lumps ☐ Nipple discharge or bleeding
☐ Number of pregnancies ____ ☐ Miscarriages/Abortions _____ ☐ Number of births _____

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☐ Last PAP smear (date and result): _____
☐ History of STD (sexually transmitted disease)? ☐Yes ☐ No Details _____
☐ Do you practice birth control? _____ If so, What type and for how long? _____
☐ Any other gynecologic problems? _____

Musculoskeletal:

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

Neuropsychological:

☐ Seizures ☐ Dizziness ☐ Areas of numbness ☐ Localized weakness ☐ Loss of balance/poor balance
☐ Anxiety ☐ Concussion ☐ Poor memory ☐ Lack of coordination ☐ Easy susceptible to stress
☐ Localized weakness ☐ Poor balance ☐ Tremors
☐ Depression ☐ Depression with active consideration of suicide OR attempted suicide OR homicide? ☐Yes ☐No
Have you ever attempted suicide? ☐No ☐Yes; when: _____
☐ Have you ever been treated for emotional problems? _____
☐ Have you 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? _____

<u>For Child's Parents (Birth History):</u>

How was the pregnancy with child? Did you have prior deliveries? Details:

Any complications (surgery, diabetes, high blood pressure, etc.)
How long was your labor?

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Was medicine used to start, augment labor, or for pain? If so, what?

Did you have a caesarean, vaginal delivery, forceps, vacuum?

Development:
When did your child roll over, hold head up, sit, crawl, walk?

Current Words:

Sleeping:
What position does your child sleep in?

Where does she/he sleep?

Frequency of awakening?

Willingness to settle down for naps/night time sleep?

Pacifier use; When?

Patient's Name _____

Parent Signature _____ Date _____