RACHEL WEST, D.O.
CONTEMPORARY MEDICINE

Pediatric Health History Information

Child's Name: _____DOB: _____Sex: _____

1. What brought you and your child in today?

_____

2. What developmental issues does your child suffer with currently if different from above?

_____

Other Health Issues:

3. Does your child suffer with other health problems?
__ Allergies __ Asthmas __ Constipation __ Diarrhea __ Eczema __ Kidney Problems
__ Lung disease __ Diabetes __ Thyroid Disease __ Heart Disease __ Seizures __ Ear Infections

Other:

_____

4. Did your child's condition change following an illness, infection, and or seizure disorder? Explain:

_____
_____

Digestive Health:

5. Does your child have periodic loose stools or diarrhea? How often and what color?

_____

6. Does your child have gas after eating a certain meal? If yes, what food?_____

7. Does your child have undigested food in his stools? _____

8. Is your child potty trained and at what age? _____

9. Does your child suffer from heartburn or reflux? _____

10. Is your child currently taking and acid blocking medication such as Tagament or Pepcid, etc.?

_____

11. Did your child digestive problems occur following a particular vaccine? Which one?

_____

12. Has your child ever produced formed stools? _____

Antibiotic History:

13. How many courses of antibiotic has your child received in his/her lifetime? Name of antibiotic if known.
_____

14. Main reason for antibiotic use:
___ Ear infection ___ Bronchitis ___ Pneumonia ___ Sinus Infection ___ Intestinal Infection
Other, please
explain:_____
_____

15. Was your child ever treated for yeast or Candida following antibiotic use? _____

Home Environment:

16. How old is your current house/apartment?
_____

17. Has your child lived in a home that had lead based paint?
_____

18. What kind of flooring does your home have? ___ Carpet ___ Wood floors ___ Tile___ Other:
_____

19. Do you use commercial cleaners at home? List them: _____

20. Has your child ever used or currently sleeps with fire resistant clothes or bedding?
_____

21. Is your child exposed to outside pesticides, fungicides, etc.?
_____

22. Please list pets and or farm animals your child is exposed to:
_____

Mother's Pregnancy and Labor:

23. Did the child's mother have any complications during pregnancy? Explain.
_____

24. Does the child's mother know her Rh factor and blood type?
_____

25. Did the mother receive Rhogam medication during her pregnancy?
_____

26. Did the mother receive any vaccinations during pregnancy? If yes, which ones?
_____

27. Did the mother receive any vaccinations after birth when breast feeding child? If yes which ones?

_____

28. During labor was your child delivered vaginally, C-Section, Forceps and or suction devices? Was there a concern for trauma?

_____

Parent's Medical History:

29. Do the child's parents suffer from any of the following medical conditions?

___ Low Thyroid ___ Thyroid Cancer ___ Parathyroid Problems ___ Night Blindness
___ Autoimmune Disorders ___ Lupus ___ Connective Tissue ___ Rheumatoid Arthritis ___ Cancer
___ High Blood Pressure ___ Other: _____

30. Did the mother have any dental work done while pregnant? If yes, please explain:

_____

31. Is there a family history of Developmental Disorders (i.e., autism, PDD, etc.)? Explain:

_____

32. Is there a family history of Neurological disorders, i.e. multiple sclerosis, etc.? Explain:

_____

33. Is there a history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis…)? Explain:

_____

34. Is there a family history of blood disorders (i.e., clots, Stokes, Hemophilia, or Platelet Disorders)? Explain:

_____

35. Is there a family history of Psychiatric disorders, i.e. depression, schizophrenia, etc.? Explain:

_____

36. Is there a history of genetic disorders? Explain:

_____

37. Is there a history of seizures or vaccine reactions? Explain:

_____

38. Is there a family history of celiac disease or gluten intolerance? Explain:

_____

Vaccination History:

39. Has your child received all the recommended vaccinations for his age? _____

40. Has your child received any of the following vaccination:
___ DTP ___ DTap ___ MMR ___ Hib ___ Hep B___ OVP ___ IVP ___ Pneumonia ___ Chicken Pox
___ Flu

Other, list:

_____

41. Do you feel your child's behavior changed after receiving a particular vaccine? Which one and explain behavior. _____

42. How long after the above vaccine did your child become sympathetic? Explain:

_____

43. Did your child receive any vaccinations when they were sick? If yes explain

_____

44. Did your child suffer from any vaccine reactions listed below:
___ Fever degrees ___ Inconsolable Screams ___ Excessive lethargy ___ Rashes ___ Hives ___ Vomiting ___ Seizures Other:

Medication Usage:

45. Is your child allergic to any medication? List:

_____

46. Has your child taken any steroid medication that is inhaled, oral use or injections? Explain:

_____

47. Has your child taken any medication for yeast or Candida infections?

_____

48. Please list all medication and supplements your child is currently taking.

_____

_____

49. Any other information you would like Dr. West to know?

_____

_____

_____

_____

_____