Pediatric Health History Information

Childs 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 offensive 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 produce 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 home?
    _____

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 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 mother receive any vaccinations during pregnancy? If yes which ones.
    _____
    _____

27. Did 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 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 mother have any dental work done while pregnant? 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, i.e. Lupus, Rheumatoid Arthritis, etc.? 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 vaccination 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:
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