

Confidential Pediatric Case History

Name: _____ Date: _____

Address: _____

City: _____ Postal Code: _____

Date of birth (Mo/Day/Yr) _____ Age _____

Parent(s) Contact: Name(s) _____

Home Phone: _____ Cell Phone: _____

Email: _____

Preferred method of communication: Home Phone Cell Phone Email

How did you find out about our clinic? _____

Please list your main health concerns in order of importance:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other	_____	_____

Supplements:

	NOW	PAST
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other	_____	_____

Childhood illnesses:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> mononucleosis |
| <input type="checkbox"/> red measles | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> ear infection(s) |
| <input type="checkbox"/> mumps | <input type="checkbox"/> strep throat | <input type="checkbox"/> tonsillitis |
| <input type="checkbox"/> rubella | <input type="checkbox"/> pneumonia | <input type="checkbox"/> other _____ |

Immunizations: List types, when given, and any reactions: _____

Prenatal/birth/neonatal history:

Birth weight _____ premature late full term

Mother's health during pregnancy

____ age	____ bleeding	____ extreme nausea
____ illness	____ toxemia	____ trauma / injury
____ stress	____ x-rays	____ high blood pressure
____ diabetes	____ medications	____ cigarettes
____ alcohol	____ drugs	____ other _____

Place of birth _____

Infant feeding

breast fed: if yes, how long? _____

formula fed: how long and types of formula? _____

Age solids began: _____ What foods? _____

Food allergy/intolerance(s) _____

Favourite foods: _____

Sample daily diet (choose a typical day, include liquids):

Hospitalizations/surgeries/accidents/serious injuries and illnesses: (describe each incident and give dates):

Family History

Identify all family members who have or have had any of the following:

_____ alcoholism	_____ allergies
_____ anemia	_____ arthritis
_____ asthma	_____ diabetes
_____ eczema	_____ epilepsy
_____ heart disease	_____ hearing loss
_____ hypoglycemia	_____ mental illness
_____ obesity	_____ stroke
_____ thyroid disorder	_____ other(s) _____

Patient's Health History

Now	Past	Never		Now	Past	Never	
___	___	___	allergies	___	___	___	fatigue
___	___	___	anemia	___	___	___	frequent infections
___	___	___	asthma	___	___	___	headaches
___	___	___	bedwetting	___	___	___	heart murmur
___	___	___	birth defects	___	___	___	high fever
___	___	___	colic	___	___	___	hyperactivity
___	___	___	cough/wheeze	___	___	___	insomnia
___	___	___	croup	___	___	___	jaundice
___	___	___	depression	___	___	___	learning problem
___	___	___	diarrhea	___	___	___	moodiness
___	___	___	dry skin	___	___	___	stuffy nose
___	___	___	earache(s)	___	___	___	thrush
___	___	___	eczema/rash	___	___	___	vomiting spells

Other? Please list: _____

