YOUR CHILD'S HEALTH HISTORY – NEWBORN TO 6 MONTHS

Dear Parents,

By filling out this questionnaire, a more complete record of your child is obtained, and it gives us a permanent history which we can refer to later. Answer all the questions you can, but don't worry about those you skip.

PATIENT'S NAME _____ TODAY'S DATE _____
Patient's Birthdate _____ Age _____ □ Male □ Female Birthplace _____
RACE (check all that apply) □ American Indian or Alaskan Native □ Asian □ Black □ Hawaiian or Pacific Islander □ White □ Declined
ETHNICITY □ Hispanic or Latino □ Non-Hispanic or Latino □ Declined
Primary Language spoken at home _____

HEALTHCARE HISTORY
Previous primary care physician: _____ Date of last visit: _____
Complementary care provider (chiropractor, acupuncturist, etc): _____

PARENTS' MAIN HEALTH CONCERNS FOR THIS CHILD: _____
_____
_____

FAMILY HISTORY (Circle those who live with this child)
Parent 1 _____ Parent 2 _____
Relationship _____Age____ Years in school ____Relationship_____ Age_____ Years in school ____
Occupation _____ Occupation _____

Parent 3 _____ Parent 4 _____
Relationship _____Age____ Years in school ____Relationship_____ Age_____ Years in school ____
Occupation _____ Occupation _____

List names, ages, sex and general health of child's brothers and sisters:
_____
_____

PREGNANCY, BIRTH AND NEWBORN HISTORY

1. Was this child born on time?	No	Yes
2. Was this baby born □ head first □ legs first □ C-section?		
3. Did the mother have an illness during her pregnancy?	Yes	No
4. Did the mother drink alcohol or use drugs during her pregnancy?	Yes	No
5. How old was the mother when the baby was born?	_____ Years	
6. Did this baby have any trouble starting to breathe?	Yes	No
7. Did this baby have any trouble while in the hospital?	Yes	No
8. How long did this baby stay in the hospital?	_____ days	
9. Did the mother have baby blues or depression after the child's birth?	Yes	No
10. Do you have friends or family you can call on when you need help?	Yes	No

DIET HISTORY

1. Does your infant breast-feed? _____	Yes	No
2. Does your infant bottle-feed? _____	Yes	No
3. What formula do you use? _____ Problems? _____		
4. Does your child have food allergies? _____	Yes	No
5. Does your child drink juice? Amount per day: _____	Yes	No
6. Does your child take any dietary supplements, herbs, or health store products?	Yes	No

Please list supplements: _____

_____

MEDICAL HISTORY

Check any of the following your baby has had:

	What age?	Please describe
□ Emergency Room visit	_____	_____
□ Broken bones	_____	_____
□ Stitches	_____	_____
□ Surgery	_____	_____
□ Hospital overnight	_____	_____
□ Specialist physician	_____	_____

□ vision problem	□ fever seizure	□ convulsions/seizures	□ bladder infection
□ hearing problem	□ anemia	□ abdominal pain	□ chicken pox
□ lung problem	□ excessive bruising	□ thyroid problem	□ chronic ear infection
□ heart problem	□ blood transfusion	□ pneumonia	□ high blood pressure
□ skin problem	□ kidney problem	□ asthma	□ constipation
			□ cancer

Has your child had any allergic reactions to any medicines, injections, foods, animals, insects, or plants? Please list:_____

_____

Does your child take medications? Please list:

_____

_____

ENVIRONMENTAL HISTORY

1. Does your child live in a house built before 1960?	Yes	No
2. Does your child drink water that has fluoride in it?	Yes	No
3. Do you have guns in your house?	Yes	No
If yes, are they locked up?	Yes	No
4. Is anyone who lives in the home a smoker?	Yes	No
5. Does your child attend daycare?	Yes	No
6. Has your child traveled outside of the USA?	Yes	No
7. Has your child been exposed to a person with tuberculosis?	Yes	No

FAMILY MEDICAL HISTORY

Do any close family members (biological mother, father, grandmother, grandfather, brothers, sisters, aunts, uncles, nieces, nephews) have any of the following? Please note who has the condition.

	Who?		Who?		Who?
□ deafness before age 20	_____	□ high cholesterol	_____	□ bedwetting after age 10	_____
□ frequent fainting	_____	□ allergies	_____	□ anemia	_____
□ convulsions/epilepsy	_____	□ thyroid problems	_____	□ asthma	_____
□ bleeding disorders	_____	□ alcoholism	_____	□ vision problem before age 12	_____
□ anesthesia problems	_____	□ liver problems	_____	□ drug abuse	_____
□ heart attacks	_____	□ kidney disease	_____	□ mental illness	_____
□ cancer	_____	□ tuberculosis	_____	□ diabetes	_____
□ mental retardation	_____	□ high blood pressure	____	□ immune problems, HIV/AIDS	_____