

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Pregnancy**

When was prenatal care initiated? \_\_\_\_\_

Please indicate if any of the following problems occurred during pregnancy:

- |                                 |                              |
|---------------------------------|------------------------------|
| ____ High Blood Pressure        | ____ German measles          |
| ____ Diabetes or sugar in urine | ____ Gonorrhea or syphilis   |
| ____ Protein in urine           | ____ Drug/Alcohol dependence |
| ____ Nausea (morning sickness)  | ____ Weight loss             |
| ____ Cigarette smoking          |                              |

Other problems during pregnancy: \_\_\_\_\_

Medications taken during pregnancy: \_\_\_\_\_

Birth place \_\_\_\_ Home \_\_\_\_ Hospital

Hospital name, city, state \_\_\_\_\_

Birth History \_\_\_\_ Vaginal \_\_\_\_ Anesthesia \_\_\_\_ Cesarean \_\_\_\_ Forceps

Birth Weight \_\_\_\_\_ lbs. \_\_\_\_ Oz. Length \_\_\_\_\_ Head circ. \_\_\_\_ Apgars \_\_\_\_\_

List any problems during labor or delivery \_\_\_\_\_

Did baby have any problems at birth (breathing, premature, meconium stain, etc...)?

Did the baby stay in the hospital longer than the mother? If so, why? \_\_\_\_\_

**Childhood**

Is/was the child breast feeding, and/or until what age? \_\_\_\_\_

Indicate what age the child entered these developmental stages:

\_\_\_\_\_ teeth \_\_\_\_\_ walking \_\_\_\_\_ talking

Indicate if the child has had any of the following problems:

- |                     |                     |                     |
|---------------------|---------------------|---------------------|
| ____ High fevers    | ____ eczema         | ____ Frequent colds |
| ____ Convulsions    | ____ Diaper rash    | ____ Bronchitis     |
| ____ Croup          | ____ Tonsillitis    | ____ Pneumonia      |
| ____ Whooping Cough | ____ Ear infections | ____ Asthma         |
| ____ Mumps          | ____ Measles        | ____ Chicken pox    |

Other past medical problems: \_\_\_\_\_

Has your child ever been hospitalized or had a surgical operation? If so, please list reasons. \_\_\_\_\_

**Current Medical Illnesses**

Please list your child's current medical problems, including those conditions which have brought him/her to Helios Integrated Medicine. \_\_\_\_\_

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### **Health Questionnaire**

- |                              |                                  |                  |
|------------------------------|----------------------------------|------------------|
| ___ Headaches                | ___ Shortness of breath          | ___ Hay fever    |
| ___ Convulsions              | ___ Wheezing or Asthma           | ___ Warts        |
| ___ Eyes-crossing            | ___ Coughing spells              | ___ Tiredness    |
| ___ Visual problems          | ___ Chest pains                  | ___ Few friends  |
| ___ Wears glasses            | ___ Burping or gas               | ___ Shyness      |
| ___ Eye irritation           | ___ Abdominal pain               | ___ Nightmares   |
| ___ Frequent ear infections  | ___ Vomiting                     | ___ Fears        |
| ___ Difficulty hearing       | ___ Diarrhea                     | ___ easily upset |
| ___ Tugging at ears          | ___ Constipation                 | ___ Over clingy  |
| ___ Ear drainage             | ___ Food Allergies               | ___ Temper fits  |
| ___ Speech Impediment        | ___ Frequent urination           | ___ Fighting     |
| ___ Dental problems          | ___ Pain with urination          | ___ Lying        |
| ___ Early tooth decay        | ___ Bedwetting (over 4 yrs.)     |                  |
| ___ Frequent colds           | ___ Daytime wetting (over 3 yrs) |                  |
| ___ Nose bleeds              | ___ Discharge from penis/vagina  |                  |
| ___ Nasal congestion         | ___ High/Low appetite            |                  |
| ___ Sore throats             | ___ Weight gain/loss             |                  |
| ___ Tonsillitis              | ___ Bleeding problems            |                  |
| ___ Allergies/animals        | ___ Recurrent fevers             |                  |
| ___ Eczema/skin rashes       | ___ Biting, Hitting, Spitting    |                  |
| ___ School/learning problems | ___ Difficult behavior           |                  |

### **Immunizations**

Please indicate kind of immunization and age at which it was given

- |                               |                 |
|-------------------------------|-----------------|
| Rubella _____                 | Measles _____   |
| Pertussis _____               | Mumps _____     |
| Tetanus _____                 | Rubella _____   |
| Polio(injected or oral) _____ | Hepatitis _____ |
| Hemophilus B _____            |                 |

### **Medications**

Allergies to any medications? \_\_\_\_\_

If your child currently or has used any of the following, please list name and dosage.

- Topical ointments \_\_\_\_\_
- Antibiotics \_\_\_\_\_
- Antihistamines \_\_\_\_\_
- Vitamins \_\_\_\_\_
- Non-Prescription \_\_\_\_\_
- Cortisone \_\_\_\_\_

### **Family- Please list any medical problems that family members have/had and age**

- Father \_\_\_\_\_
- Mother \_\_\_\_\_
- Siblings \_\_\_\_\_
- Maternal Grandmother \_\_\_\_\_
- Maternal Grandfather \_\_\_\_\_
- Paternal Grandmother \_\_\_\_\_
- Paternal Grandfather \_\_\_\_\_
-