

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 _____
- Sblings _____
- Maternal Gradmother _____
- Maternal Grandfather _____
- Paternal Grandmother _____
- Paternal Grandfather _____

Indicate if child has been bothered by any of the following problems:
