Children's Medical History Forms

Today's Date: _____

Name: _____ Age: _____ Birthdate: _____

Astrology: Sun: _____ Ascendant: _____ Moon: _____

Current Height: _____ Weight: _____ Eye color: _____Hair color: _____

Hobbies/Interests: _____

Mother: _____ Telephone(s): _____

Father: _____ Telephone(s): _____

Child's primary address: _____

Pediatrician/Family Doctor: _____ Telephone: _____

Current medications/herbs/supplements: _____

ALLERGIES: _____

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Any known details of child's conception, gestation and birth: _____

_____

Birthdate: _____ City/State: _____ Time: _____ Details and length

of labor: _____

Type of delivery: _____ Home? _____ Hospital? _____

Medications/Epidural? _____

Full Term? _____ Premature? _____ Condition at birth/Apgar score: _____

Length at birth: _____ Weight at birth: _____ Other: _____

Vaccinations:

MMR Date(s): _____ Reactions: _____

DPT Date(s): _____ Reactions: _____

HIB Date(s): _____ Reactions: _____

Hep B Date(s): _____ Reactions: _____

Chicken Pox Date(s): _____ Reactions: _____

Other Date(s): _____ Reactions: _____

Childhood Illnesses:

Measles Date/Age: _____ Symptoms and treatments: _____

_____

Mumps Date/Age: _____ Symptoms and treatments: _____

_____

Chicken Pox Date/Age: _____ Symptoms and treatments: _____

_____

Other Date/Age: _____ Symptoms and treatments: _____

_____

Colds/ Earaches Dates/Age: _____ Symptoms and treatments: _____

_____

Sore Throats/ Tonsillitis Dates/Age: _____ Symptoms and treatments: _____

_____

Asthma Dates/Age: _____ Symptoms and treatments: _____

_____ Hospitalized? _____

Bronchitis/ Pneumonia Dates/Age: _____ Symptoms and treatments: _____

_____ Hospitalized? _____

Viruses/Flu Dates/Age: _____ Symptoms and treatments: _____

_____

Accidents/Injuries/Surgeries:

Date/Age: _____ Details: _____

Treatments/Hospitalization: _____

Date/Age: _____ Details: _____

Treatments/Hospitalization: _____

Date/Age: _____ Details: _____

Treatments/Hospitalization: _____

FAMILY HISTORY: [e.g., MGM = Maternal Grandmother; PGGF = Paternal Great Grandfather, etc.]

Problem/Disease	Family Member	Details	Age First Acquired	Age of Death

Anemia/Clotting Disorders: _____

Diabetes: _____

Heart Attack/Stroke: _____

High BP/High Cholesterol: _____

Tuberculosis: _____

Cancers: _____

_____

Addictions: _____

Mental Illness: _____

Sexually Transmitted Diseases: _____

Other: _____

Describe your child's overall personality: _____

_____

Anger – what causes it? _____ How do they show their anger: __

_____

Major griefs/losses in their life: _____ and how they have

reacted: _____

3 worst fears and their response to fear: _____

_____

Food & Drink:

Cravings/Favorites: _____

Aversions: _____

Sensitivities/Allergies: _____

Thirsty for water: _____ Quantity: _____ Cold/Iced: _____ Room temp.: _____ Doesn't drink water much: _____

Usually drinks (type of juice, soda, etc.) _____

Child is usually warm and doesn't want a lot of clothes/blankets: _____

Child is usually cold and likes to bundle up: _____

Affects of COLD: (weather, wet, food/drink): _____

Affects of HEAT: (weather, sun, food/drink): _____

Urinary Habits: Frequency: _____ Color: _____ Odor: _____

Problems/History: _____

Bowel Habits: Frequency: _____ Color: _____ Odor: _____

Problems/History: _____

Any signs of impending puberty: _____

Headaches: Frequency: _____ Details: _____

_____ Treatments: _____

Skin Problems: Type: _____ Where on body: _____

Coloration: _____ Discharge: _____ Odor: _____

Sleep: Bedtime: _____ # hours: _____ Body Position: _____

Restless? ___ Deep sleeper? ___ Easily awakened? ___ Well rested upon waking? ___ Other: _____

Dreams: Remembered? _____ Recurrent themes: _____

In color? _____ Details: _____

Nightmares? _____ Details/recurrent themes: _____

Any specific Dream since making this appointment? _____

What are the main reasons you are seeking Naturopathic/Homeopathic care for your child? _____

_____

_____

Anything else you would like me to be aware of? _____

_____

_____