# Center for Integral Health

**PEDIATRIC HISTORY** Referred by: Today's Date:

| Name: | Sex: M F | Age: | Date of Birth: |
|---|---|---|---|
| Bill to: | | Parent's S. S. # | |
| Address: Street | City | State | Zip |
| Home Phone: ( ) | | Work Phone: ( ) | |

**MAJOR COMPLAINTS IN ORDER OF IMPORTANCE TO YOU:**

| COMPLAINT | SINCE | CAUSE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?**

| MEDICATION | SINCE | ADVERSE EFFECTS |
|---|---|---|
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| | | |
| | | |
| | | |

**List Any Allergies:** ______________________________

HAVE YOU TAKEN CORTISONE TYPE DRUGS? YES ☐ or NO ☐

ANY PROLONGED COURSES OF ANTIBIOTICS? ________ WHEN? ______________________

WHY? ______________________ LIST ANY ADVERSE EFFECTS? ______________________

**WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Abscesses | | Allergies | | Anemia | | Arthritis | | Asthma | |
| Bleeding | | Cancer | | Chicken Pox | | Cold Sores | | Depression | |
| Diabetes | | Epilepsy | | Gall stones | | Goiter | | Gonorrhea | |
| Gout | | Hay Fever | | Heart Disease | | Hepatitis | | Herpes | |
| Jaundice | | Influenza | | Kidney Disease | | Leukemia | | Malaria | |
| Measles | | Mono | | Mumps | | Parasites | | Peritonitis | |
| Pleurisy | | Pneumonia | | Rheumatic Fever | | Rubella | | Scarlet Fever | |
| Sex Abuse | | Skin Disease | | Strep Throat | | Sinusitis | | Stroke | |
| Sunstroke | | Syphilis | | Tonsillitis | | Tuberculosis | | Typhoid Fever | |
| Warts | | Whooping Cough | | Worms | | Yellow Fever | | | |

ANY OTHER MAJOR CONDITIONS?______________________________

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Which ones? ______________________________

______________________________

**WHAT OPERATIONS HAVE YOU HAD?**

| OPERATION | WHEN | COMPLICATIONS |
|---|---|---|
| | | |
| | | |
| | | |

**WHAT MAJOR INJURIES HAVE YOU HAVE YOU HAD?**

| INJURY | WHEN | LONG TERM EFFECTS |
|---|---|---|
| | | |
| | | |

## PERINATAL & DEVELOPMENTAL HISTORY

Pregnancy problems ____________________
Length of pregnancy ________ Pregnancy Number ________ Delivery Type ____________
Labor and Delivery problems ____________________
Birth Wt __________ Ht __________ Apgars __________ Jaundice ____________
Other newborn problems ____________________
Feeding history ____________________
Developmental milestones: walked ________________ said words ____________
sentences ________________ first teeth ________________
other milestones ____________________
Other unusual habits or idiosyncrasies ____________________

### IMMUNIZATIONS

DPT/DT 1. ________ 2.________ 3. ________ 4. ________ 5. ________
Polio 1. ________ 2.________ 3. ________ 4. ________ 5. ________
Measles 1. ________ 2.________ Mumps 1. ________ 2.________
Rubella 1. ________ 2.________
Hib (hemophilus influenza type B) 1. ________ 2.________ 3. ________ 4. ________
Hepatitis B 1. ________ 2.________ 3. ________
TB tests (date and result) ____________________
Any adverse effects from immunizations? ____________________

### INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS OR ANY OTHER MAJOR AILMENTS, HAVE AFFECTED YOUR BLOOD RELATIVES

| Alcoholism | | Allergies | | Arthritis | | Asthma | | Cancer | | Depression | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | | Epilepsy | | Gonorrhea | | Gout | | Hay Fever | | Heart Disease | |
| Insanity | | Paralysis | | Pneumonia | | Skin Disease | | Syphilis | | Tuberculosis | |

| RELATIVE | AGE IF ALIVE | AGE AT DEATH | AILMENTS |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Brothers | | | |
| Sisters | | | |
| Children | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Maternal Aunts/Uncles | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Paternal Aunts/Uncles | | | |

### ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

| PHYSICIAN | FOR WHAT CONDITIONS? | TREATMENT? |
|---|---|---|
| | | |
| | | |

### HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

| PHYSICIAN | FOR WHAT CONDITIONS? | WHEN?? |
|---|---|---|
| | | |
| | | |
| | | |

"I,________________________ have received a copy of *The Center for Integral Health's* **Notice or Privacy Practices**. Signature (Parents signature-on peds form)________________________ Date________________