A Healing Place Wheaton, IL

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

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 *A Healing Place's* **Notice or Privacy Practices.**

Signature (Parents signature-on peds form)_____ Date_____