OSTEOPATHIC HEALTHCARE OF MAINE

PEDIATRIC HEALTH HISTORY

LEGAL NAME: ____________________________________ **DOB:**___________________ **DATE:**__________________

PREFERRED NAME (nickname):__________________________**SEX AT BIRTH** _____________________________________

PARENT:_____________________**PARENT:**_____________________ **WHO REFERRED YOU?**______________________

Problem	Location	How Long?
1.		
2.		
3.		
4.		

Describe what caused the problem and what makes it better or worse:

1.____

____

2.____

____

3.____

____

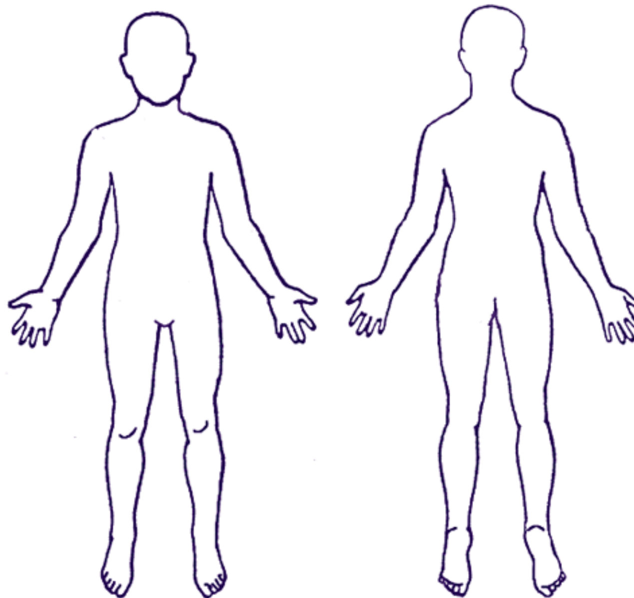
4.____

____

Symptom Drawing

Please mark the areas on the diagrams below where you feel symptoms using the codes indicated. Include all the affected areas.

Ache	Sharp	Tight/Stiff	Pressure	Numb	Burning	Tingling
~~	>>>>	/////	++++	oooo	xxxx	****
~~	>>>>	/////	++++	oooo	xxxx	****



How bad is your pain on an average day?

None____**Worst**

0 1 2 3 4 5 6 7 8 9 10

Review of Systems

General
[ ] Fatigue
[ ] Fever
[ ] Chills
[ ] Sleep Problems
[ ] Sweats

Nutritional
[ ] Weight loss
[ ] Weight gain
[ ] Poor appetite
[ ] Feeding problems

Head
[ ] Headaches
[ ] Migraines
[ ] Head injuries
[ ] Head pain

Eyes
[ ] Discharge
[ ] Eye pain
[ ] Visual problem
[ ] Visual change
[ ] Lazy eye
[ ] Redness

Nose
[ ] Nose bleeds
[ ] Congestion
[ ] Frequent URI
[ ] Nasal Obstruction
[ ] Sinus Infection
[ ] Snoring

Mouth
[ ] Bleeding gums
[ ] Dental problems/procedures
[ ] Root canals
[ ] Pain

Ears
[ ] Hearing impairment
[ ] Ear infection
[ ] Ringing in ears
[ ] Pain
[ ] Tubes

Throat
[ ] Frequent sore throats
[ ] Pain
[ ] Postnasal drip
[ ] Hoarseness/change in voice
[ ] Swallowing problems
[ ] Tonsil problems

Respiratory
[ ] Wheezing
[ ] Asthma
[ ] Cough
[ ] Shortness of breath

Cardiovascular
[ ] Chest pain
[ ] Heart disease
[ ] Palpitations
[ ] Irregular heartbeat
[ ] Murmur
[ ] Congenital heart problems
[ ] POTS

Gastrointestinal
[ ] Abdominal pain
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Vomiting
[ ] Bloating
[ ] Heartburn/reflux
[ ] Colic
[ ] Jaundice

Musculoskeletal
[ ] Joint pain
[ ] Muscle stiffness/pain
[ ] Muscle weakness
[ ] Muscle cramps/spasms
[ ] Joint swelling
[ ] Toe walking

Psychiatric
[ ] Anxiety
[ ] Depression
[ ] Panic attacks
[ ] PTSD
[ ] ASD/Autism
[ ] ADHD/ADD
[ ] OCD
[ ] Eating Disorder
[ ] PANS/PANDAS

Skin
[ ] Itching
[ ] Rash
[ ] Eczema
[ ] Psoriasis
[ ] Acne/rosácea
[ ] Stretch marks

Neurological
[ ] Numbness
[ ] Tingling
[ ] Dizziness/vertigo
[ ] Coordination/balance issues

Endocrine
[ ] Thyroid problems
[ ] Diabetes
[ ] PMS
[ ] Hormone therapy
[ ] Adrenal problems
[ ] Hot flashes
[ ] Use of Birth Control

Hematologic/Lymph
[ ] Swollen glands
[ ] Blood clots
[ ] Easy bruising
[ ] Clotting disorder
[ ] Anemia

Allergies/Immune
[ ] Sneezing
[ ] Hives
[ ] Itching/watery eyes
[ ] Dust/environmental allergies
[ ] Food allergies
[ ] Vaccine reaction

Genitourinary Female
[ ] UTI
[ ] Bladder/urinary irritation
[ ] Dysmenorrhea/painful menses
[ ] Endometriosis
[ ] Ovarian problems

Genitourinary Male
[ ] UTI
[ ] Bladder/urinary irritation
[ ] Hernia
[ ] Problems with urination

Other symptoms not listed:
[ ] ______________________

Diagnostic Testing:

(I.E: XRAY, CAT SCAN, MRI, BONE SCAN, EMG, BONE DENSITY, EEG, PFT, BLOOD, URINE TESTS) None: [ ]

Please list the date, body area, and result of the imaging report or test

1. ____
2. ____
3. ____
4. ____

Allergies/sensitivities: None: [ ]

Please list any reactions you have to medications, foods, environment, or chemicals, date of onset and the reaction you have.

Allergy	Date Started (if known)	Reaction

Medications: None:[ ]

Please list all medications, date started, and dosage information. Include all prescriptions, supplements, and homeopathic remedies.

Prescription/Supplement/Name	Date started	Dosage

VITAL SIGNS: **Height: _____ ft ________ in** **Weight: _____________ lbs.**

Family History:

Relative	Age	Gender	Medical Problems	Check if deceased	Cause of Death
Father					
Mother					

Health Problems in Blood Relatives:

[ ] Chronic Back pain [ ] Ruptured Discs [ ] Fibromyalgia [ ] Thyroid Disease [ ] Depression

[ ] Anxiety [ ] ADD/ADHD [ ] Autoimmune Disease [ ] Heart Disease [ ]Obesity

[ ] Substance Abuse [ ] Cancer [ ] Lyme/Co-Infection Disease

[ ] Other/please specify:______________________________

Past & Present Medication Conditions:

[ ] Colic [ ] ADD/ADHD [ ] Scoliosis [ ] Sensory Integration Problems

[ ]Seizures [ ] Depression/Anxiety [ ]Fatigue [ ] Autistic Spectrum Disorder

[ ]Feeding problems [ ] Eating disorder [ ] Colic reflux [ ] Obesity

[ ] Change in Bowel Habits [ ] Lyme Disease

[ ] Other/please specify:____________________________________

Immunizations:

Is your child up to date with all vaccines? [ ] Yes [ ] No

If your child is not current with all vaccines, do they have a modified schedule or reactions to any vaccines?

____

BIRTH INFORMATION:

Prenatal problems: ____

Duration of labor (pushing, stress, length of time): ____

Delivery type (c-section, vaginal, forceps, vacuum):____

Procedure complications: ____

Postpartum (NICU, infections, bottle or breast fed?)____

Social History:

Who lives in the home (same household/split home)?____

Does the child attend daycare, public, private, or home school? ____

Health Maintenance/Diet:

Environmental exposures (smokers in/out of home, pets, mold exposure, previous tick bites?:____

Physical Activity/sports/outside activity____

Screen time (tablet, iPad, video games/ minutes/hours per day) ____

Sleep/rest (quality of sleep, how many hours per day) ____

Fluid intake (type/ how much per day) ____

Food Choices:

Diet: [ ] Organic [ ] Gluten Free [ ] Diary Free [ ] Vegetarian [ ] Other/please specify:_______________________

Surgical History: None: [ ]

[ ] Tonsils/Adenoids [ ] Tympanostomy (Ear Tubes) [ ] Appendix [ ] Fracture repair [ ] Circumcision

[ ] Ligament/tendon repair [ ] Hernia repair [ ] Frenectomy (Tongue tie repair) [ ] Other:______________

Hospitalizations:

Hospital	Dates	Diagnosis	Treatment