Pediatric History

Child's Condition History

When did the problem first begin? ______________________ ☐ GRADUAL ☐ SUDDEN ☐ UNKNOWN

Has this happened before? Please describe: ______________________

Any bowel or bladder problems since this began? ______________________

Have you seen any other doctors for this problem? ______________________

If yes, how long ago: ______________________

What were the results of any past treatment? ______________________

____

How is the problem now? ☐ RAPIDLY IMPROVING ☐ IMPROVING SLOWLY ☐ ABOUT THE SAME ☐ WORSE

Please list any medications being taken: ______________________

____

Has your child ever sustained a sports injury? ______________________

Has your child sustained an injury from an auto accident? ______________________

Please detail any serious falls or breaks your child has suffered (eg. fall from crib, chair, stairs, swing, slide)

____

Has your child ever suffered from?

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Heart Trouble
- ☐ Chronic Earaches
- ☐ Sinus Trouble
- ☐ Scoliosis
- ☐ Bed Wetting
- ☐ Orthopedic problems
- ☐ Neck Problems
- ☐ Arm or Leg Problems
- ☐ Joint Problems
- ☐ Backaches
- ☐ Poor Posture
- ☐ Anemia
- ☐ Colic
- ☐ Broken Bones
- ☐ Digestive Disorders
- ☐ Poor Appetite
- ☐ Stomach Aches
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hypertension
- ☐ Colds / Flu
- ☐ Headaches
- ☐ ADD / ADHD
- ☐ Ruptures / Hernia
- ☐ Muscle Pain
- ☐ Growing Pains
- ☐ Asthma
- ☐ Walking Trouble
- ☐ Sleeping Problems

Pediatric History

Child Information

Today's Date: ____________________________ Child's Age: ____________

Name: ________________________________ Date of Birth: ________________________________

Address: ______________________________ Birth Height: ________________________________

City/Province/Postal Code: ______________ Birth Weight: ________________________________

Home Phone: ____________________________ Current Height: ______________________________

Parent Contact

Personal Health Number: ____________________________

Mothers Name: ________________________ Mobile: ____________________ DOB: __________________

Fathers Name: ________________________ Mobile: ____________________ DOB: __________________

Emergency Contact Name ______________________ #____________ Relationship ________

Doctor Information

Pediatrician/Family MD: ______________________________ Office Location: ____________________

Last Visit: ____________________ Reason for visit: ____

Birth Information

Were there any complications during the birthing process?

____

Check what applies: C SECTION ☐ EPIDURAL ☐ HOME BIRTH ☐ HOSPITAL BIRTH ☐

FORMULA ☐ BREAST FEEDING ☐

Childs Current Condition

Purpose of visit: ☐ WELLNESS CHECK-UP ☐ INJURY OR ACCIDENT? ☐ OTHER

Please describe the condition you as best you can: