PEDIATRIC HEALTH HISTORY

Osteopathic Wellness

253 Main St, Yarmouth ME 04096

Phone: 207-615-6956

Fax: 207-850-2228

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHY IS THE CHILD HERE TODAY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH HISTORY: Choose one: Vaginal C-section

Any complications after birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Currently breast or bottle fed? Other? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems with feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any delay of developmental milestones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICINES, SUPPLEMENTS, and HERBS (with DOSAGE please): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of last physical examination: \_\_\_\_\_\_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST MEDICAL HISTORY: List all major illnesses,infections, injuries, traumas (including emotional), and surgeries

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**FAMILY MEDICAL HISTORY** (medical illnesses your family members have):

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYMPTOMS:** Check off any of the following symptoms you have/had ***RECENTLY*** experienced within the last **ONE WEEK:**

**GENERAL:** **HEAD:**

\_\_\_ weight change \_\_\_ headaches \_\_\_ eye pain \_\_\_ runny nose \_\_\_ painful teeth

\_\_\_ tired/weak \_\_\_ glaucoma \_\_\_ hearing loss \_\_\_ stuffy nose \_\_\_ bleeding gums

\_\_\_ dizzy/fainting \_\_\_ cataracts \_\_\_ noise in ears \_\_\_ nosebleeds \_\_\_ dentures

\_\_\_ fever/chills \_\_\_ blurry vision \_\_\_ earaches \_\_\_ sore throats \_\_\_ goiter

\_\_\_fussy/inconsolable \_\_\_ hearing aids \_\_\_ voice change \_\_\_ swollen glands

**RESPIRATORY:**

\_\_\_ cough \_\_\_ cough with phlegm \_\_\_ cough with blood \_\_\_ wheezing \_\_\_ short of breath

**HEART & CIRCLATION:**

\_\_\_ high blood pressure \_\_\_ heart races or skips beats \_\_\_ chest pain \_\_\_ short of breath after climbing steps

\_\_\_ short of breath while lying in bed \_\_\_ legs swell \_\_\_ legs hurt or cramp when walking \_\_\_ varicose veins

**DIGESTIVE:**

\_\_\_ trouble swallowing \_\_\_ heartburn \_\_\_ poor appetite \_\_\_ nausea \_\_\_ vomiting (with blood?) \_\_\_abdominal pain

\_\_\_ diarrhea \_\_\_ constipation \_\_\_ excess belching or passing gas \_\_\_ change in stool (with blood?)

\_\_\_ hemorrhoids \_\_\_ rectal pain \_\_\_ jaundice \_\_\_ gallbladder pain

**URINARY:**

\_\_\_bed wetting \_\_\_ burning with urination \_\_\_ frequent urination \_\_\_\_ change in urine stream (with blood?)

\_\_\_ frequent urinary infection \_\_\_ lose urine if you cough or sneeze \_\_\_ kidney stones

**MUSCULOSKELETAL:**

\_\_\_ pain in muscles or joints \_\_\_ morning stiffness \_\_\_ backache \_\_\_ sciatica \_\_\_ low back pain \_\_\_ arthritis

\_\_\_ gout \_\_\_short leg \_\_\_ wear a shoe lift \_\_\_ scoliosis \_\_\_ spondylolisthesis \_\_\_muscle spasms \_\_\_limping

**NEUROLOGICAL:**

\_\_\_ blackouts \_\_\_ seizures \_\_\_ numbness or loss of sensation \_\_\_ tingling or "pins and needles"

\_\_\_ tremors or other involuntary movements \_\_\_\_ weakness in arms or legs \_\_\_ trouble walking

**OTHER:**

\_\_\_ heat or cold intolerance \_\_\_ excessive sweating \_\_\_ excessive thirst or hunger \_\_\_excessive urination

\_\_\_ nervousness \_\_\_ tension \_\_\_depression \_\_\_ difficulty with memory \_\_\_confusion \_\_\_ skin changes / rash