PEDIATRIC HEALTH HISTORY
Osteopathic Wellness
253 Main St, Yarmouth ME 04096
Phone: 207-615-6956
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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):
____
____
____
____

Date of last physical examination: ___________ By whom? ____

ALLERGIES: ____

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

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