Original Date:
Dates Revised:

SNOHOMISH VALLEY HOLISTIC MEDICINE
PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of the medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status of parent(s) or guardian: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last well child exam:**	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed	
Was child delivered vaginally or by C-section?	**If C-section, was it a planned surgery?**

Surgeries or birth complications:

Date	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Has this child ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List any prescribed drugs and over-the-counter drugs, such as vitamins, herbal supplements, and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Activity	☐ Rarely active—below normal activity for age		
	☐ Moderately active		
	☐ Normal activity for age and development		
	☐ Hyperactivity—overly active compared to others his/her age		
Diet	Was/is this child breastfed?	☐ Yes	☐ No
	If yes, was/is diet ever supplemented with formula before age 6 months?	☐ Yes	☐ No
	At what age were solids introduced?		
	Does this child have any strong food aversions? If so, what foods?		
	What percentage of the child's diet consists of canned or processed foods?		
Caffeine (either consumed by child or breastfeeding mom)	☐ None ☐ Coffee ☐ Tea ☐ Cola		
	# of cups/cans per day?		
Alcohol (consumed by breastfeeding mom)	Do you drink alcohol?	☐ Yes	☐ No
	If yes, do you wait 24 hours before breastfeeding?	☐ Yes	☐ No
	Was child exposed to alcohol during pregnancy?	☐ Yes	☐ No
Tobacco exposure	Is the child exposed to second hand smoke at home?	☐ Yes	☐ No
	Was the child exposed to nicotine or other drugs during pregnancy?	☐ Yes	☐ No
Safety	Is there a working smoke alarm in the house?	☐ Yes	☐ No
	Is the child always properly restrained in a car-seat or seatbelt while in a vehicle?	☐ Yes	☐ No
	Does child attend Daycare or preschool? If so, how often?	☐ Yes	☐ No
	Has your child ever been exposed to asbestos, lead paint, toxic mold, or other environmental hazards in their home?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Siblings**	☐ M ☐ F	
Mother				☐ M ☐ F	
Grandmother *Maternal*	☐ M ☐ F			☐ M ☐ F	
Grandfather *Maternal*	☐ M ☐ F			☐ M ☐ F	
Grandmother *Paternal*	☐ M ☐ F			☐ M ☐ F	
Grandfather *Paternal*	☐ M ☐ F			☐ M ☐ F	

DIGESTIVE HEALTH

List the foods and amounts of each food child has eaten in the last 24 hours (or what child might eat in a typical day) If child is exclusively breastfed, please write mother's diet and breastfeeding schedule:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

How many cups of water does the child drink in addition to other fluids?

Check if child has the following symptoms after meals: ☐ gas ☐ pain ☐ bloating

How often does the child have a bowel movement?

What is the consistency of his/her stool? ☐loose ☐well-formed, easy to pass ☐ hard ☐ pebbly ☐ other:

Check if child has the following: ☐ diarrhea ☐ constipation If so, how often?

Check if you have noticed the following in child's stool: ☐ blood ☐ mucus ☐ undigested food

Does the child ever have unusual colored stools? If yes, what color?

OTHER PROBLEMS

Check if the child has or has had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	