



Mona Bhalla, ND, LLC
 443 NE Knott Street
 Portland, Oregon 97212
 503-282-5350

***Pediatric patient health history questionnaire
 Six years of age to adolescence***

Name _____ **Today's date** _____ **Age** _____
Last First MI

Parent or guardian _____
Father Mother Guardian

Parent or guardian SSN _____ **Date of birth** _____

Sex Female Male

Address _____
Street/POB City State Zip code

Email _____

Telephone number Home _____ Work _____ Cell _____

Name and address of doctor's office/hospital/clinic where your child's health records are kept

Office/hospital/clinic name Street/POB City State Zip code

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems?

- | | |
|---|---|
| 1 | 3 |
| 2 | 4 |

MEDICATIONS

Now = medication currently being taken

Past = medication taken at one time or another

	<i>Now</i>	<i>Past</i>		<i>Now</i>	<i>Past</i>
<i>Aspirin</i>	_____	_____	<i>Asthma medication</i>	_____	_____
<i>Tylenol</i>	_____	_____	<i>Decongestant</i>	_____	_____
<i>Inhalers</i>	_____	_____	<i>Ibuprofen</i>	_____	_____
<i>Antibiotics</i>	_____	_____	<i>Topical steroids</i>	_____	_____
<i>Antihistamine</i>	_____	_____	<i>Other</i>	_____	_____

Does your child have any allergies to foods, drugs, or other allergens in your environment (cats, mold, dust)? Yes No If yes, list and explain _____



MEDICAL HISTORY (check all that are applicable)

- Chicken pox* *Scarlet fever* *Bronchitis* *Asthma*
- Measles* *Pneumonia* *Rubella* *Mumps*
- Frequent colds* *Eczema* *Croup* *Other*
- Tonsillitis: how many times?* _____ *Ear infections: how many times?* _____

X-RAYS AND SPECIAL STUDIES

	<i>When</i>	<i>Where</i>	<i>Results</i>
<input type="checkbox"/> <i>Electroencephalogram</i>			
<input type="checkbox"/> <i>Psychological evaluation</i>			
<input type="checkbox"/> <i>Hearing</i>			
<input type="checkbox"/> <i>Speech/language</i>			

INJURIES, SURGERIES, AND HOSPITALIZATIONS

IMMUNIZATIONS

- Measles* *Polio* *MMR* *Small pox* *Diphtheria*
- Mumps* *DPT* *Tetanus* *Influenza* *Other*

Any adverse reactions to immunizations (please specify)?

FAMILY HISTORY

- Heart disease* *Diabetes* *Birth defects* *Cancer* *Mental illness*
- Hypertension* *Arthritis* *Tuberculosis* *Allergies* *Hay fever*
- Eczema* *Other*

Previous pregnancies by natural mother, miscarriages, or complications:

Mother's age at child's birth _____

Mother's health during pregnancy

- Bleeding* *Hypertension* *Illness* *Cigarettes*
- Nausea* *Diabetes* *Thyroid problems* *Alcohol, drugs*
- Physical or emotional trauma*



BIRTH HISTORY/Term

Full Premature Late Weight at birth _____
Length of labor _____ Complications? Yes No Explain _____

SYMPTOMS

Please circle: Y = a condition your child has now P = a condition your child had in the past N = a condition your child has never had

Hives	Y	P	N	Burning of urine	Y	P	N	Bloody urine	Y	P	N
Eczema	Y	P	N	Frequent urination	Y	P	N	Cries easily	Y	P	N
Bleeding gums	Y	P	N	Heart murmur	Y	P	N	Nervous	Y	P	N
Nose bleeds	Y	P	N	Vomiting spells	Y	P	N	Sleep problems	Y	P	N
Acne	Y	P	N	Anemia	Y	P	N	Night sweats	Y	P	N
High fever	Y	P	N	Stomach aches	Y	P	N	Sensitive to light	Y	P	N
Chronic rash	Y	P	N	Jaundice	Y	P	N	Body/breath odor	Y	P	N
Hearing loss	Y	P	N	Easy bruising	Y	P	N	Motion/car sickness	Y	P	N
Diarrhea	Y	P	N	Flat feet	Y	P	N	No appetite	Y	P	N
Sore throats	Y	P	N	Constipation	Y	P	N	Nightmares	Y	P	N
Gas	Y	P	N	Canker sores	Y	P	N	Wheezing	Y	P	N
Joint pain	Y	P	N	Cough	Y	P	N	Dizzy spells	Y	P	N
Hair loss	Y	P	N	Frequent headaches	Y	P	N	Frequent colds	Y	P	N
Unusual fears	Y	P	N	Bleeding tendency	Y	P	N	Excessive fatigue	Y	P	N

Any condition not mentioned? _____

DIET

Describe your child's typical daily diet

Does your child have any food intolerances you know of? Yes No

If yes, please explain

