



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**

\_\_\_\_\_  
\_\_\_\_\_