NATIONAL UNIVERSITY OF Natural Medicine
HEALTH CENTERS

PERSONAL HEALTH HISTORY-INFANT / CHILD (Birth-10 years)

Patient: _____ _____ _____ Date of Birth _____
Last Name First Name Middle Name

Form filled out by: ☐ Self ☐ Parent ☐ Other:_____

What is the main reason for your visit to our Health Center today?

_____

Allergies: Does your child have any allergies to the following? **(Please select all that apply)**

☐ Sulfa ☐ Penicillin ☐ Tetracycline ☐ Aspirin ☐ Codeine ☐ Latex ☐ Pollen
☐ Cats ☐ Dogs ☐ Mold ☐ Dust ☐ Bees ☐ Soy ☐ Wheat
☐ Shellfish ☐ Fish ☐ Peanuts ☐ Eggs ☐ Milk
☐ Other _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements your child takes:

Name of Medication/Supplement	Strength	Frequency Taken

Medical Conditions: Does your child have or have a history of the following? **(Please select all that apply)**

☐ Asthma ☐ Diabetes ☐ Cancer ☐ Pneumonia
☐ Depression/Anxiety ☐ Chronic Ear Infections ☐ Digestive Problems ☐ Thyroid Disorder
☐ Allergies ☐ Kidney Disease ☐ Skin Disorders ☐ Strep Throat

Surgeries / Hospitalizations: Has your child had any of the following surgeries? **(Please list below)**

List Surgeries / Hospitalizations here:

_____
_____
_____

Immunization History: Has child had any of the following vaccines and/or illnesses? **(Please select all that apply)**

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella
☐ Rotavirus ☐ Polio ☐ Hepatitis B ☐ Hepatitis A
☐ Hib ☐ Pneumococcal ☐ Flu (Influenza) ☐ HPV
☐ Meningococcal ☐ Diphtheria, Tetanus, Pertussis (DTaP / Tdap)
☐ Other: _____

Date of last dental exam (if applicable):		
Date of last vision exam (if applicable):		
Is your child having any problems with hearing?	☐ Yes	☐ No
Is your child having any sleeping problems?	☐ Yes	☐ No

Family History: Do you have a family history of any of the following? (**Please "X" the boxes that apply to you**)

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcohol/ Drug Addiction												
Autism Spectrum Disorder												
Asthma												
Cancer												
Heart Disease												
Depression												
Diabetes												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Mental Illness												
Stroke												
Vision Problems												

Birth / Infant History: Please answer the following questions:

Was your child delivered via :	☐ Vaginal	☐ C-Section
Were there any complications with your child's birth?	☐ Yes	☐ No
Was/is your child breast fed?	☐ Yes	☐ No
If so, for how long? :		

Social History: Please answer the following questions regarding your social history:

Who lives in the home? :		
In the past year, have you worried you will run out of food before you can afford more?	☐ Yes	☐ No
How many times per day does your child get their teeth brushed? :		
Does your child always use a car seat or seatbelt?	☐ Yes	☐ No
Has your child ever been tested for lead?	☐ Yes	☐ No
Does anyone in your household smoke or does your child spend time in any place where people smoke?	☐ Yes	☐ No
Do you have any concerns about your child's social skills?	☐ Yes	☐ No
Does your child exhibit any behavioral problems?	☐ Yes	☐ No
Is your child having any problems in school?	☐ Yes	☐ No

Have there been any major changes in the family lately: (Please check all that apply):

☐ None ☐ Move ☐ Job Change ☐ Separation ☐ Divorce ☐ Death in Family
☐ Other: _____

Review of Systems: **Please circle below: Y= Yes, present condition. N=No, never had the condition.**

Constitutional

Fever	Y N	Chills	Y N	Weight Loss	Y N
Malaise/Fatigue	Y N	Sweating	Y N	Weakness	Y N

Skin

Rash	Y N	Itching	Y N	Color changes	Y N

Head, Ears, Eyes, Nose, Throat

Headaches	Y N	Ringing in Ears	Y N	Nosebleeds	Y N
Ear Pain	Y N	Ear Discharge	Y N	Congestion	Y N
Sore Throat	Y N	Migraine headaches	Y N		

Eyes

Blurred Vision	Y N	Double Vision	Y N	Light Sensitivity	Y N
Eye Pain	Y N	Eye Discharge	Y N	Eye Redness	Y N

Cardiovascular

Chest Pain	Y N	Palpitations	Y N	Shortness of breath lying down	Y N

Respiratory

Cough	Y N	Coughing up Blood	Y N	Sputum Production	Y N
Shortness of breath	Y N	Wheezing	Y N	Asthma	Y N

Gastrointestinal

Heartburn	Y N	Nausea	Y N	Vomiting	Y N
Abdominal Pain	Y N	Diarrhea	Y N	Constipation	Y N
Blood in Stool	Y N	Black/Tarry Stools	Y N		

How often does your child have a bowel movement? _____

Genitourinary

Painful Urination	Y N	Urgency	Y N	Frequency	Y N
Blood in urine	Y N	Flank Pain	Y N	Incontinence	Y N
Frequent infections	Y N	Bedwetting	Y N		

Male Reproductive

Hernias	Y N	Testicular masses	Y N	Circumcision performed	Y N

Female Reproductive

Vaginal discharge	Y N	Genital Itching	Y N		

Musculoskeletal

Muscle Pain	Y N	Neck Pain	Y N	Back Pain	Y N
Joint pain	Y N	Falls	Y N	Muscle spasms	Y N

Endocrine/Heme/Allergies

Excessive thirst	Y N	Env. Allergies	Y N	Easy Bruising/Bleeding	Y N
Cold intolerance	Y N	Excessive hunger	Y N	Heat intolerance	Y N
Diabetes _____		Thyroid problems_____			

Neurological

Dizziness	Y N	Tingling	Y N	Tremor	Y N
Sensory Change	Y N	Speech Change	Y N	Seizures	Y N
Fainting	Y N	Numbness	Y N	Paralysis	Y N

Emotional (Psychiatric)

Depression	Y N	Suicidal Ideas	Y N	Substance Abuse	Y N
Hallucinations	Y N	Nervous/Anxious	Y N	Insomnia	Y N
Memory Loss	Y N	Mood swings	Y N	Tension/stressed	Y N
Cutting / Self Harm	Y N				