Eric Toder, D.O.

Health History Questionnaire- (Pediatric, Age 0 to 18 years old) Please help us provide your child with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be absolutely confidential. If you have any questions or need clarification, please ask us. Thank You.

Child's Name:_____**Age:**_____ **Sex: F M** **Date:**_____

Birthday:_____**Home #**_____**Email:**_____

Address:_____
(street) (city) (State) (Zip Code)

Parent's Name: _____ Cell **#:**_____

Parent's Name:_____ Cell#:_____

In EMERGENCY, notify:_____ **Phone**:_____

Family physician/pediatrician:_____ **Phone:**_____

Who referred you to this office? _____

Has your child received care from an osteopathic physician or received an osteopathic treatment in the past? __ No __Yes__

If yes, details _____

With what main problem would you like us to help your child?

Please be as specific as you can about when the problem began and the extent it interferes with your child's daily activities:

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment, if any, have you tried in the past? Has it helped?

Any recent travel outside of the country?__No __Yes Details:_____
Any sick contacts within the past few weeks? __No __Yes Details:_____

Past Medical History:

__asthma	__seizure history	__heart disease	__kidney disease	__allergies
__cancer	__ADD/ADHD	__autism	__cerebral palsy	__pneumonia
__skin disorder	__rheumatic fever	__thyroid disease	__meningitis	__diabetes
__reflux/GERD	__stroke	__hepatitis	__tuberculosis	

__anemia/blood disorder __high blood pressure __other:_____
__fracture(s) or other trauma (auto accidents, falls, head injuries, etc); details:_____

_____

__previous hospitalizations; details:_____

Did you choose to immunize your child?__Yes __No if so, is your child up-to-date on his/her vaccinations? __Yes __No Comments:_____

Birth History:
Gestation: __Early; number of weeks___ ___On time ___Late; number of weeks___
Delivery: Length of labor_____hours ___Normal, spontaneous vaginal delivery
__Forceps delivery __Vacuum extraction __Induced
__C-section; reason:_____

Medicine (if any) used to start or augment labor, or for pain: _____

Complications (gestational diabetes, high blood pressure, early labor, pre-eclampsia, jaundice, etc.):_____

Diet History:

__Breastfeeding OR __Formula (name:_____) Frequency:_____
__Table-foods (please describe a typical day's diet):
Breakfast Lunch Dinner Snack(s)

Past Surgical History:
__Tonsillectomy __Appendectomy __Hernia, repair, location:_____
__ other, details:_____

Dental history:
__Extractions __Braces __Head gear __Root canal __Reconstructive surgery

Development:
Age when child was able to: sit-up____ crawl____ walk____ vocabulary (how many words now?)_____

Drug allergies:
__None Or __Specific drug allergies; please list name of medication(s) and reaction, if known:
_____

Current medications:
__My child does not take any medication on a regular basis
__My child takes the following medications occasionally-please list specific medication(s):_____

_____

__My child takes the following medications on a regular basis-please list specific medication(s):_____

_____

Family History:
Please check the appropriate box to indicate specific illnesses for each family member as requested, if known):

	Living? Yes/No	Age	Allergies	Asthma/COPD	Cancer, type	Diabetes	Heart disease	High blood pressure	Seizure	Stroke	Other (describe)
Father											
Mother											
Maternal grandmother											
Maternal grandfather											
Paternal grandmother											
Paternal grandfather											
Brother											
Brother											
Sister											
Sister											

Social History:
Child lives with:_____
Pets in the home: __NO __YES; please describe:_____
Exercise (type, frequency):_____
Current school/day-care:_____
Safety concerns (smoke detector in home? Car seat/seatbelts? Exposure to swimming pools or bodies of water? Bicycle safety/helmets? Response to strangers? Peer pressure? Etc.)_____

_____

Any exposure to tobacco, alcohol, "street" drugs?_____
Hobbies:_____

System Reviews: Has your child experienced any of the following (see below) within the past few weeks?

General:
__Fever __Chills __Night sweats __Appetite changes __Sleeping changes __Weight gain/loss

Skin/Hair:
__Rashes __Eczema __Ulceration __Loss of hair __Change in moles/new moles __Changes in skin texture
__Any other problems?_____

Head, Eyes, Ears, Nose and throat:
__Dizziness __Ringing in ears __Change in hearing __Ear pain __Nose bleed
__Cataracts/Glaucoma __Eye pain __Glasses __Change in vision __Sore throat
__Headache/migraines __Grinding teeth/jaw licks
__Last optometry exam: _____ Last dental exam:_____
__Any other problems?_____

Cardiovascular:
__High blood pressure __Low blood pressure __Chest pain __Fainting __Irregular heartbeat
__Blood clots __Dizziness/lightheadedness __Phlebitis __Difficulty breathing with activity
__Cold hand/feet __Any other heart or blood vessel problems?_____

Respiratory:
__Cough __Coughing up blood __ Asthma __Bronchitis __Pneumonia __Pain with deep breath
__Difficulty breathing when lying down __Production of phlegm; what color:_____
__Any other lung problems?_____

Gastrointestinal:
__Nausea __Vomiting __Diarrhea __Constipation __Bloating/belching/indigestion
__Black stools __Blood in stools __Rectal pain __Bad breath __Hemorrhoids
__Abdominal pain/cramps __Difficulty swallowing __Vomiting blood
__Any other problems with stomach or intestines? _____

Genitourinary:
__Pain on urination __Frequent urination __ Blood in urine __Urgency to urinate __Hesitancy
__Unable to hold urine __Kidney stones __Decrease in flow __Sores on genitals __impotence
__Number of night-time awakening to urinate_____ __Any particular color to your urine?_____
__Any other genital or urinary problems?_____

Musculoskeletal:
__Neck pain __Muscle pain __Knee pain __Muscle weakness __Foot/ankle pain
__Hip pain __Shoulder pain __Hand/wrist pain __Join stiffness/pain
__Back pain; where?_____
__Any other joint or bone problems? _____

Neuropsychological:
__Seizure __Dizziness __Areas of numbness __Localized weakness __Loss of balance/poor balance
__Anxiety __Concussion __Poor memory __Lack of coordination __Easily susceptible to stress
__Depression __Has your child ever been treated for emotional problems?_____
__Has your child ever lost consciousness?(please describe details)_____
__Any other neurological or psychological problems?_____

Hematologic:
__Easy bruising __Easy bleeding __Prolonged bleeding __Any other hematologic problems?_____

Endocrine:
__Strong thirst __Large volume of urine Hair loss/growth __Weight change __Sleeping changes
__Any other endocrine (thyroid, pituitary, pancreas, adrenals, etc.) problems?_____
_____

Gynecologic (female patient only):
__Age at first menses_____Date of last menstrual period_____
__Length of menstrual cycle (amount of time between each period)_____days __Regular/Irregular periods
__Length of menses (bleeding)_____days __Unusual character of bleeding/clots __Painful periods
__Number of pregnancies___ __Miscarriages/Abortions_____ __Number of births
__Vaginal discharge/sore __Change in body/psyche prior to period
__Last PAP smear (date and results):_____
__Breast lumps __Nipple discharge or bleeding
__History of STD (sexual transmitted disease)?__YES __NO Details_____
__Does your child practice birth control?____ if so, what type and for how long?_____
__Any other gynecologic problems?_____

_____ _____
Parent's Signature **Date**