

Prescott Clinix and erbzRx™
CHILD HEALTH HISTORY QUESTIONNAIRE
 (Ages: New Born to 12)



Name of Child: _____ Date form completed: ____/____/____

Gender: Female Male Date of Birth: ____/____/____

How did you hear about us or who referred you: _____

Attention, Parents or Guardians: As age permits, please have your child participate as much as possible in completing this form. Complete those parts that apply to your child as age allows. **Omit the sections that do not apply to you or your child.**

This form was completed by: Mother Father Child Other _____
 (check all that apply)

MEDICATION ALLERGY AND INTOLERANCE: List any medications or supplement you are allergic to or which caused unpleasant side effects; include the name of the substance, the age it occurred, how it was taken (mouth, vein, etc), what reaction occurred, and the treatment if given. Use additional sheets if necessary.

Prescription Medication	Date	Route given	Reaction	Any treatment given
Example: Penicillin	02/2000	By mouth	Hives, breathing difficulty	None
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICATIONS: List medicines, both prescribed by a physician and obtained without a prescription (those that you can buy on your own), that you are currently taking or have taken recently. Complete as much as you are able. Including the name of the medicine, the strength of the medicine (dosage), how often you take it (frequency), date started and date stopped if you are no longer using it. **Please bring all your medication to your appointment.** Use the other side of this sheet or additional sheets if necessary.

Medication	Dose	Frequency (times per day)	Started	Stopped
Example: Benadryl	25 mg	1 pill 2 times per day	1999	2003
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

VITAMINS, MINERALS, AND OTHER NUTRITIONAL SUPPLEMENTS: As above, please list your nutritional supplements to include vitamins, minerals, herbs, homeopathic remedies, folk remedies, and other nutritional or alternative therapies. Please include the form of the supplement (pill/liquid, etc.), and the dosage (mg, IU, etc.). **Please bring all your supplements to your appointment.** Use additional sheets if necessary.

Vitamin/Herb/Supplement	Dose	Frequency (times per day)	Started	Stopped
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Antibiotics: List the number of times you have been on antibiotics such as **Penicillin, Tetracycline, Amoxicillin, Keflex, Ceflor, Erythromycin,** or other antibiotics: No Yes, the number of times given antibiotics: _____. Please check any of the reasons listed as to why you were prescribed antibiotics, include as many as apply:

- Acne/Skin Condition Colds Tonsillitis/Sleep/Throat Ear Infection(s) Bladder/Kidney Infection
- Other: _____

Steroids: Have you ever taken an oral cortisone preparation such as **Prednisone, Decadron, Medrol,** or others? If yes, state how many times. No Yes The number of times given steroid pills: _____. Have you received a cortisone type “shot” such as **Depo Medrol, Decadron, Kenalog,** or others? No Yes The number of times given steroid injections: _____.

CHIEF COMPLAINT: In your own words, what are your main complaints? State the nature and duration of symptoms:

Severity (of chief complaint): Mild Mild to Moderate Moderate Moderate to severe Severe

Interferes with my life, how?: _____

Please list **handicaps/disabilities**: _____

During the **12 months preceding** the onset of your present condition(s), check those that apply and briefly comment:

- Was under severe stress: _____
- Moved to new residence or home: _____
- Traveled outside the U.S.: _____
- Involved in wilderness activity: _____
- Experienced an injury or an acute illness: _____
- Took drugs or medications: _____
- Had chemical or toxic exposure: _____

REVIEW OF SYMPTOMS: Check the symptoms that apply to you. Note whether the symptom is past, now or both:

<input type="checkbox"/> Past <input type="checkbox"/> Now - Tired without effort	<input type="checkbox"/> Past <input type="checkbox"/> Now - Fever	<input type="checkbox"/> Past <input type="checkbox"/> Now - Flu like symptoms
<input type="checkbox"/> Past <input type="checkbox"/> Now - Chills	<input type="checkbox"/> Past <input type="checkbox"/> Now - Night sweat	<input type="checkbox"/> Past <input type="checkbox"/> Now - Cold Intolerance
<input type="checkbox"/> Past <input type="checkbox"/> Now - Heat Intolerance	<input type="checkbox"/> Past <input type="checkbox"/> Now - Weight gain _____ lbs.	<input type="checkbox"/> Past <input type="checkbox"/> Now - Weight Loss _____ lbs.
<input type="checkbox"/> Past <input type="checkbox"/> Now - Attention Difficulties	<input type="checkbox"/> Past <input type="checkbox"/> Now - Concentration Problems	<input type="checkbox"/> Past <input type="checkbox"/> Now - Can't Decide Easily
<input type="checkbox"/> Past <input type="checkbox"/> Now - Thinking Difficulties	<input type="checkbox"/> Past <input type="checkbox"/> Now - Poor Memory (long term)	<input type="checkbox"/> Past <input type="checkbox"/> Now - Poor Memory (short term)
<input type="checkbox"/> Past <input type="checkbox"/> Now - Disorientation	<input type="checkbox"/> Past <input type="checkbox"/> Now - Hyperactivity	<input type="checkbox"/> Past <input type="checkbox"/> Now - Constant Movement
<input type="checkbox"/> Past <input type="checkbox"/> Now - Low Activity (hypo)	<input type="checkbox"/> Past <input type="checkbox"/> Now - Sleep too much	<input type="checkbox"/> Past <input type="checkbox"/> Now - Difficulty falling asleep
<input type="checkbox"/> Past <input type="checkbox"/> Now - Frequent awakening	<input type="checkbox"/> Past <input type="checkbox"/> Now - Nightmares	<input type="checkbox"/> Past <input type="checkbox"/> Now - Restless Legs
<input type="checkbox"/> Past <input type="checkbox"/> Now - Un-refreshed Sleep	<input type="checkbox"/> Past <input type="checkbox"/> Now - Dizziness	<input type="checkbox"/> Past <input type="checkbox"/> Now - Fainting/Blacking out
<input type="checkbox"/> Past <input type="checkbox"/> Now - Convulsions/Seizure	<input type="checkbox"/> Past <input type="checkbox"/> Now - Speech problem	<input type="checkbox"/> Past <input type="checkbox"/> Now - Burning sensations
<input type="checkbox"/> Past <input type="checkbox"/> Now - Electrical Zaps	<input type="checkbox"/> Past <input type="checkbox"/> Now - Numbness	<input type="checkbox"/> Past <input type="checkbox"/> Now - Tingling
<input type="checkbox"/> Past <input type="checkbox"/> Now - Headaches	<input type="checkbox"/> Past <input type="checkbox"/> Now - Weakness	<input type="checkbox"/> Past <input type="checkbox"/> Now - Clumsiness
<input type="checkbox"/> Past <input type="checkbox"/> Now - Tremors	<input type="checkbox"/> Past <input type="checkbox"/> Now - Repeats same action(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now - Head Banging
<input type="checkbox"/> Past <input type="checkbox"/> Now - Rocking	<input type="checkbox"/> Past <input type="checkbox"/> Now - Picking	<input type="checkbox"/> Past <input type="checkbox"/> Now - "Pill rolling" actions
<input type="checkbox"/> Past <input type="checkbox"/> Now - Paralysis	<input type="checkbox"/> Past <input type="checkbox"/> Now - Anxiety/Nerves on edge	<input type="checkbox"/> Past <input type="checkbox"/> Now - Apprehension
<input type="checkbox"/> Past <input type="checkbox"/> Now - Fearful	<input type="checkbox"/> Past <input type="checkbox"/> Now - Other specific fear:	<input type="checkbox"/> Past <input type="checkbox"/> Now - Flashback Memories:
<input type="checkbox"/> Past <input type="checkbox"/> Now - Fearful of going out		
<input type="checkbox"/> Past <input type="checkbox"/> Now - Panic Episodes		
<input type="checkbox"/> Past <input type="checkbox"/> Now - Depressed Mood	<input type="checkbox"/> Past <input type="checkbox"/> Now - Hopelessness	<input type="checkbox"/> Past <input type="checkbox"/> Now - Guilt
<input type="checkbox"/> Past <input type="checkbox"/> Now - Loss of interest in play	<input type="checkbox"/> Past <input type="checkbox"/> Now - Suicidal Thoughts	<input type="checkbox"/> Past <input type="checkbox"/> Now - Suicidal Attempt(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now - Angry	<input type="checkbox"/> Past <input type="checkbox"/> Now - Irritable	<input type="checkbox"/> Past <input type="checkbox"/> Now - Mood Swings
<input type="checkbox"/> Past <input type="checkbox"/> Now - Jekyll/Hyde personality	<input type="checkbox"/> Past <input type="checkbox"/> Now - Stress @ work	<input type="checkbox"/> Past <input type="checkbox"/> Now - Stress @ home
<input type="checkbox"/> Past <input type="checkbox"/> Now - Anorexia	<input type="checkbox"/> Past <input type="checkbox"/> Now - Binge eating	<input type="checkbox"/> Past <input type="checkbox"/> Now - Impulsive Eating
<input type="checkbox"/> Past <input type="checkbox"/> Now - Purging	<input type="checkbox"/> Past <input type="checkbox"/> Now - Sugar cravings	<input type="checkbox"/> Past <input type="checkbox"/> Now - Anti-social behaviors
<input type="checkbox"/> Past <input type="checkbox"/> Now - Compulsive behaviors	<input type="checkbox"/> Past <input type="checkbox"/> Now - Obsessive behaviors	<input type="checkbox"/> Past <input type="checkbox"/> Now - Defiant behaviors
<input type="checkbox"/> Past <input type="checkbox"/> Now - Temper Tantrums	<input type="checkbox"/> Past <input type="checkbox"/> Now - Hallucinations	<input type="checkbox"/> Past <input type="checkbox"/> Now - Vision change
<input type="checkbox"/> Past <input type="checkbox"/> Now - Blurry vision	<input type="checkbox"/> Past <input type="checkbox"/> Now - Spots/Floaters	<input type="checkbox"/> Past <input type="checkbox"/> Now - Glasses
<input type="checkbox"/> Past <input type="checkbox"/> Now - Contact lenses	<input type="checkbox"/> Past <input type="checkbox"/> Now - Pain in eye(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now - Red eye(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now - Dryness	<input type="checkbox"/> Past <input type="checkbox"/> Now - Light sensitivity	<input type="checkbox"/> Past <input type="checkbox"/> Now - Swelling of eye(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now - Itchy eye(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now - Cataract(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now - Glaucoma

<input type="checkbox"/> Past <input type="checkbox"/> Now – Infection eye(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Head Tenderness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Jaw Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Neck Stiffness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Neck Tenderness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swelling
<input type="checkbox"/> Past <input type="checkbox"/> Now – Swollen Glands	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lump(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Infections ear(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Drainage/discharge ear(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Earaches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hearing loss
<input type="checkbox"/> Past <input type="checkbox"/> Now – Wears Hearing Aid	<input type="checkbox"/> Past <input type="checkbox"/> Now – Itching ear(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Noise Sensitivity
<input type="checkbox"/> Past <input type="checkbox"/> Now – Tinnitus	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vertigo	<input type="checkbox"/> Past <input type="checkbox"/> Now – Redness ear(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Frequent Colds	<input type="checkbox"/> Past <input type="checkbox"/> Now – Congestion/Nose	<input type="checkbox"/> Past <input type="checkbox"/> Now – Runny Nose
<input type="checkbox"/> Past <input type="checkbox"/> Now – Post Nasal Drip	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nose Blockage	<input type="checkbox"/> Past <input type="checkbox"/> Now – Itching Nose
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sneezing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nose Bleeds	<input type="checkbox"/> Past <input type="checkbox"/> Now – Snoring
<input type="checkbox"/> Past <input type="checkbox"/> Now – Facial Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sinus Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cracked Lips
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sore Lips	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dry Mouth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sores in mouth
<input type="checkbox"/> Past <input type="checkbox"/> Now – Ulcers in mouth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bad Breath	<input type="checkbox"/> Past <input type="checkbox"/> Now – Coated Tongue
<input type="checkbox"/> Past <input type="checkbox"/> Now – Abnormal Taste	<input type="checkbox"/> Past <input type="checkbox"/> Now – Metallic Taste	<input type="checkbox"/> Past <input type="checkbox"/> Now – Gum Problems
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bleeding Gums	<input type="checkbox"/> Past <input type="checkbox"/> Now – Toothache	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loose/Missing Teeth
<input type="checkbox"/> Past <input type="checkbox"/> Now – Grinding Teeth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chewing difficulty	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dentures
<input type="checkbox"/> Past <input type="checkbox"/> Now – Silver (metal) Fillings	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sore Throats – frequent	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swollen Tonsils
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hoarseness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Short of Breath @ rest	<input type="checkbox"/> Past <input type="checkbox"/> Now – Short of Breath-exertion
<input type="checkbox"/> Past <input type="checkbox"/> Now – Short of Breath-lying	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wheezing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough – occasional
<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough-all the time	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough – dry	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough – phlegm
<input type="checkbox"/> Past <input type="checkbox"/> Now – Chest Pain @ rest	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chest Pain – exertion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chest Pressure
<input type="checkbox"/> Past <input type="checkbox"/> Now – Fast Heart Rate	<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow Heart Rate	<input type="checkbox"/> Past <input type="checkbox"/> Now – Palpitations
<input type="checkbox"/> Past <input type="checkbox"/> Now – Coldness of hands/feet	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blue hands/feet	<input type="checkbox"/> Past <input type="checkbox"/> Now – Fingertips discolored
<input type="checkbox"/> Past <input type="checkbox"/> Now – Fingertips white	<input type="checkbox"/> Past <input type="checkbox"/> Now – Leg pain when walking	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swelling feet/legs
<input type="checkbox"/> Past <input type="checkbox"/> Now – Ulcers of feet/legs	<input type="checkbox"/> Past <input type="checkbox"/> Now – Varicose veins	<input type="checkbox"/> Past <input type="checkbox"/> Now – Change of Appetite
<input type="checkbox"/> Past <input type="checkbox"/> Now – Eats Dirt/Paint/Plaster	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ravenous Appetite	<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor Appetite
<input type="checkbox"/> Past <input type="checkbox"/> Now – On a Weight Loss Diet	<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty Chewing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty Swallowing
<input type="checkbox"/> Past <input type="checkbox"/> Now – Indigestion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heartburn	<input type="checkbox"/> Past <input type="checkbox"/> Now – Use Anti-acids
<input type="checkbox"/> Past <input type="checkbox"/> Now – Belching	<input type="checkbox"/> Past <input type="checkbox"/> Now – Reflux	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nausea
<input type="checkbox"/> Past <input type="checkbox"/> Now – Vomiting	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vomiting Blood	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vomiting – Projectile
<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Lump/Mass	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Bloating	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Distension
<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Distress from eating	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hernia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Yellow Jaundice		

FOOD INTOLERANCES: Please list past and/or present food triggered symptoms (any symptoms).

Food	Symptom(s)	Food	Symptom(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – _____	_____	<input type="checkbox"/> Past <input type="checkbox"/> Now – _____	_____
<input type="checkbox"/> Past <input type="checkbox"/> Now – _____	_____	<input type="checkbox"/> Past <input type="checkbox"/> Now – _____	_____
<input type="checkbox"/> Past <input type="checkbox"/> Now – _____	_____	<input type="checkbox"/> Past <input type="checkbox"/> Now – _____	_____

<input type="checkbox"/> Past <input type="checkbox"/> Now – Colitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Gas/Flatus-excessive	<input type="checkbox"/> Past <input type="checkbox"/> Now – Constipation
<input type="checkbox"/> Past <input type="checkbox"/> Now – Uses Laxatives	<input type="checkbox"/> Past <input type="checkbox"/> Now – Diarrhea	<input type="checkbox"/> Past <input type="checkbox"/> Now – Can't Control Bowels
<input type="checkbox"/> Past <input type="checkbox"/> Now – Change in Bowel Habits	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abnormal Stools	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood in Stools
<input type="checkbox"/> Past <input type="checkbox"/> Now – Black/Tar-like Stools	<input type="checkbox"/> Past <input type="checkbox"/> Now – Undigested Food in Stool	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Fissure
<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Fistula	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hemorrhoids	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Itching	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bed Wetting	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bladder Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Ur Infec.	<input type="checkbox"/> Past <input type="checkbox"/> Now – Urine Dribbling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Painful Urination
<input type="checkbox"/> Past <input type="checkbox"/> Now – Urine Urgency	<input type="checkbox"/> Past <input type="checkbox"/> Now – Urine Frequency	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wake Up to Urinate

<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow Stream	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loss of Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Urinate very little
<input type="checkbox"/> Past <input type="checkbox"/> Now – Urinate a lot	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood in Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cloudy Urine
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dark Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Red Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Tea Colored Urine

FEMALE:	<input type="checkbox"/> Past <input type="checkbox"/> Now- Breast Lump	<input type="checkbox"/> Past <input type="checkbox"/> Now– Nipple Discharge
<input type="checkbox"/> Past <input type="checkbox"/> Now–Breast Pain/ Tenderness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pelvic Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now- Genital Rash
<input type="checkbox"/> Past <input type="checkbox"/> Now – Genital Lesions	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Discharge	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Itch
<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Odor	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bleeding between cycles
<input type="checkbox"/> Past <input type="checkbox"/> Now – Irregular Bleeding	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mid Cycle Pain	

– Premenstrual Symptoms :		
<input type="checkbox"/> Past <input type="checkbox"/> Now – Heavy Menses	<input type="checkbox"/> Past <input type="checkbox"/> Now – Menstrual Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Menstrual Headache
<input type="checkbox"/> Past <input type="checkbox"/> Now – Infrequent Menses	<input type="checkbox"/> Past <input type="checkbox"/> Now – Too Frequent Menses	<input type="checkbox"/> Past <input type="checkbox"/> Now – No Menses
– Menses Onset @ age _____	– Cycle every _____ days	– Lasting for _____ days

MALE:	<input type="checkbox"/> Past <input type="checkbox"/> Now – Genital Lesions	<input type="checkbox"/> Past <input type="checkbox"/> Now – Scrotal Rash/Lesions
<input type="checkbox"/> Past <input type="checkbox"/> Now – Penile Rash/Lesions	<input type="checkbox"/> Past <input type="checkbox"/> Now – Penile Discharge	<input type="checkbox"/> Past <input type="checkbox"/> Now – Testicle Pain

BOTH MALE AND FEMALE ANSWER THE FOLLOWING QUESTIONS:

<input type="checkbox"/> Past <input type="checkbox"/> Now – General Aches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Artificial Joints	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Loss (atrophy)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bone Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Limited Motion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Morning Stiffness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Spasms	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Weakness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Twitches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Joints Hurt/Painful	<input type="checkbox"/> Past <input type="checkbox"/> Now – Joints Stiff
<input type="checkbox"/> Past <input type="checkbox"/> Now – Joints Red	<input type="checkbox"/> Past <input type="checkbox"/> Now – Joint Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Neck Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Mid Back Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Low Back Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sciatica
<input type="checkbox"/> Past <input type="checkbox"/> Now – Arm Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Arm Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hand Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hand Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Leg Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Leg Cramps
<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Burning	<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Cramps
<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Flat Feet	<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty with Walking
<input type="checkbox"/> Past <input type="checkbox"/> Now– Rashes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Eczema	<input type="checkbox"/> Past <input type="checkbox"/> Now – Excessive Dry Skin
<input type="checkbox"/> Past <input type="checkbox"/> Now – Itchy Skin	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sweaty Skin	<input type="checkbox"/> Past <input type="checkbox"/> Now – Skin Redness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Scar(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Unusual Skin Texture	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cracking Skin
<input type="checkbox"/> Past <input type="checkbox"/> Now – Scaling Skin	<input type="checkbox"/> Past <input type="checkbox"/> Now – Moles	<input type="checkbox"/> Past <input type="checkbox"/> Now – Moles Changing
<input type="checkbox"/> Past <input type="checkbox"/> Now – Increase skin pigment	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loss Skin Pigment	<input type="checkbox"/> Past <input type="checkbox"/> Now – Acne
<input type="checkbox"/> Past <input type="checkbox"/> Now – Skin Cancer	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hives	<input type="checkbox"/> Past <input type="checkbox"/> Now – Warts
<input type="checkbox"/> Past <input type="checkbox"/> Now – Skin Ulcers	<input type="checkbox"/> Past <input type="checkbox"/> Now – Brittle Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Thickened Nails
<input type="checkbox"/> Past <input type="checkbox"/> Now – Discolored Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pitted Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Inflamed Cuticles
<input type="checkbox"/> Past <input type="checkbox"/> Now–Ingrown Nail	<input type="checkbox"/> Past <input type="checkbox"/> Now – Fungal Infection Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blue Nails
<input type="checkbox"/> Past <input type="checkbox"/> Now – “Spoon” Shaped Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dry Hair	<input type="checkbox"/> Past <input type="checkbox"/> Now – Brittle Hair

<input type="checkbox"/> Past <input type="checkbox"/> Now – Oily Hair	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dandruff	<input type="checkbox"/> Past <input type="checkbox"/> Now – Scalp Itch
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hair Loss	<input type="checkbox"/> Past <input type="checkbox"/> Now – Increased Hair Growth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Processes/Dye Hair
<input type="checkbox"/> Past <input type="checkbox"/> Now – Rapid Growth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow Growth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Overweight
<input type="checkbox"/> Past <input type="checkbox"/> Now – Underweight	<input type="checkbox"/> Past <input type="checkbox"/> Now – Can't Gain Weight	<input type="checkbox"/> Past <input type="checkbox"/> Now – Can't Lose Weight
<input type="checkbox"/> Past <input type="checkbox"/> Now – No Thirst	<input type="checkbox"/> Past <input type="checkbox"/> Now – Low Blood Pressure	<input type="checkbox"/> Past <input type="checkbox"/> Now – Easy Bleeding
<input type="checkbox"/> Past <input type="checkbox"/> Now – Thyroid Goiter	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hot Flashes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Too Thirsty
<input type="checkbox"/> Past <input type="checkbox"/> Now – No Thirst	<input type="checkbox"/> Past <input type="checkbox"/> Now – Low Blood Pressure	<input type="checkbox"/> Past <input type="checkbox"/> Now – Easy Bleeding
<input type="checkbox"/> Past <input type="checkbox"/> Now – Prolonged Bleeding	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Clot	<input type="checkbox"/> Past <input type="checkbox"/> Now – Easy Bruising
<input type="checkbox"/> Past <input type="checkbox"/> Now – Frequent Bruising	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lymph Node Swelling	

Allergy & Environmental: Check those symptoms affected by the following environmental patterns:

Pattern	Nose	Eye	Lung	Skin	Other Body Symptom
–Worse Indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
–Improved Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
–Increased symptoms within 30 minutes of going to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
–Symptoms recur/increase with cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse in Air Conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse dusting/sweeping (dust exposure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse outdoors from 4:40-8:30 p.m.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse in cool evening air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse damp places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse basements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse with mold/mildew exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse raking or exposure to leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse September to heavy/killing frost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse outdoors 7-11:00 a.m.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Improved indoors, esp. with air conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Improved with rain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse exposure to feed mills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse in barns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse after exposure to cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse after exposure to dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse exposure to other animal: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Insect Reaction, (name of insect(s) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse with/after exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse when hot or overheated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse with cold exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Present or worse winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Present or worse spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Present or worse summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Present or worse fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Present all year (all the time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse with storm fronts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse with wind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse on rainy day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse on dry day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Worse with high humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Worse from the following **Chemical Exposure:**

	Nose	Eye	Lung	Skin	Other Body Symptom
– Gasoline Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Exhaust Fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Asphalt, Tar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Polishes, Floor Waxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Moth Balls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Varnish, Paint, Shellac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– New Cars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Latex Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Soaps/Detergents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Chlorinated Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Ammonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Bleach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Household Cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Disinfectants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Cosmetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Hair Spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Air Fresheners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Newsprint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Tobacco Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Metals/Jewelery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Insect Sprays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Rubber Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
– Other Chemical(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Home/School Environment: Complete the following to the best of your knowledge. Skip if unknown.

Home Environment:

Pets: Dog(s) Cat(s) Other: _____

Do you live in a: Single house Apartment Mobile Home Other: _____

Age of the house/place you live: _____ How long have you lived there: _____

Live on a Farm In a wooded area Near a swamp Near Stream City Suburbs

Near chemical factory/smoke stack Heavy Traffic Near power lines/transformers

Did your medical symptoms or problems begin after moving into your current residence? Yes No Don't Know

Are your symptoms better when you are away from your current residence? Yes No Don't Know

What part of your residence do you feel best? _____ Feel the worst? _____

In which part of the house do you spend most time? _____

Is the **Garage:** Attached Detached Breezeway Underneath

Is the **Basement:** Dry Damp Musty Flooded in past Can see mold

Is the **Insulation:** Fiberglass Cellulose Sawdust Styrofoam Urea Foam

Are the **Carpets:** Wall to Wall Area Rugs Cotton Wool Synthetic

Is the **Heat:** Electric Gas Oil Solar Forced Hot Air Coal Space Heater
 Wood Burning Stove Other: _____

Hot Water Heater: Electric Gas Oil Solar Other: _____

Air Conditioner: Central Air Room Units Other: _____

Humidifier: On Furnace Room Unit Dehumidifier

Is the **Stove:** Gas Electric Is the **Dryer:** Gas Electric

Air Purifier: Central Unit Room Units

Are the **filters:** HEPA Charcoal UV lights Fiberglass Electrostatic Ozone Ionizer
 Other: _____

Other: Use Air Fresheners Use Moth Balls Use fluoridated toothpaste

Termite Treatment: No Yes Chemical Name: _____

Pesticide Use: No Yes Chemical Name: _____

Lawn Sprays: No Yes Chemical Name: _____

School Environment:

At **school** my symptoms are: Worse Better Sawdust Same No Change

Is there any particular **place or room** at school which bothers you or aggravates your symptoms?

Has the air quality in your school been a concern to you or others? Explain:

Growth and Development:

Approximate weight (in pounds) at the following ages:

1 year _____ 2 years _____ 3 years _____ 5 years _____ 10 years _____

Approximate age of first tooth: _____

List at what age did your child first perform the following: complete those that apply:

Developmental Milestone	Age	Developmental Milestone	Age
Lift Head		Spoke Clearly	
Roll Over		Bladder Trained	
Sit Up		Bowel Trained	
Stand Up		Dry @ Night	
Walk		Dresses Alone	
Drank from Cup		Rode 2 wheel bicycle	
Knows Name			

- Not sure about the **above** but everything seemed on schedule.
- Formal **developmental evaluation** was done, which revealed: _____

Puberty development, list age of: **First Menses:** _____ **Breast development:** _____ **Pubic Hair:** _____

Are there any difficulties in sexual adjustment/development? _____

PAST MEDICAL HISTORY: Answer to the best of your ability, any question you don't know, just leave blank.

Preconception History:

Was the pregnancy: Planned Planned, with preconception counseling/education Unplanned

Was the pregnancy: Wanted Unwanted

What form of birth control was used prior to conception: _____

How long before conception was it discontinued? _____

In the *six months prior to conception* was there any:

- Toxic chemical exposure to mother or father, explain: _____
- Poor diet of mother or father, explain: _____
- Medication use (prescription or over the counter) use by mother or father: _____
- Drug or alcohol use by mother or father, explain: _____
- Infections in mother or father, explain: _____
- Stress in mother or father, explain: _____
- Other medical problems, explain: _____
- Was there any thing else that occurred prior to conception that you feel may be important? _____

Prenatal (During Pregnancy) History:

- Received OB/Midwife Care Did not receive OB/Midwife Care

Any problems or complication while mother was pregnant with the child?

- High Blood Pressure Diabetes Venereal Disease Measles or other infection
- Smoke Cigarettes Use alcohol/drugs Caffeine use
- Child very active in womb Child had frequent hiccups while in mother's womb
- Mother took medications, explain: _____
- Chemical exposure, explain: _____
- Stress during pregnancy, explain: _____
- Abnormal Ultrasound, explain: _____
- Abnormal test during pregnancy: _____
- Other Pregnancy problem, explain: _____

Birth History:

Where were you born? (Hospital, City and State:) _____

Was your delivery: NL Vaginal C-section Forceps Vacuum used Breech Pitocin was used
 Antibiotics given in labor Magnesium Sulfate was given in labor Complications, explain: _____

When were you delivered: Term (near/at due date) Early by ____ weeks Late by ____ weeks

Childs Blood Type, if known: A+ A- B+ B- AB+ AB- O+ O-

Were there any problems while you were in the hospital nursery?

- Was in NICU Breathing problems Low Oxygen Needed breathing machine (ventilator)
- Infection Feeding problem Blood problems (mismatch Rh etc.) Jaundice Needed light therapy

Birth Weight: _____ lbs. _____ oz. Birth Length: _____ inches

Medications given to baby: _____

Other problems, please explain: _____

Past Illnesses: Check the disease or conditions that apply to you. Please note whether the problem is now, past or both:

<input type="checkbox"/> Past <input type="checkbox"/> Now - Birth Defects	<input type="checkbox"/> Past <input type="checkbox"/> Now – Genetic Illness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chicken Pox
<input type="checkbox"/> Past <input type="checkbox"/> Now – Croup	<input type="checkbox"/> Past <input type="checkbox"/> Now – Measles	<input type="checkbox"/> Past <input type="checkbox"/> Now – German Measles
<input type="checkbox"/> Past <input type="checkbox"/> Now – Polio	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rheumatic Fever	<input type="checkbox"/> Past <input type="checkbox"/> Now – Scarlet Fever
<input type="checkbox"/> Past <input type="checkbox"/> Now – Whooping Cough	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mono (EBV)	<input type="checkbox"/> Past <input type="checkbox"/> Now – CMV (virus)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Coxsackie Virus	<input type="checkbox"/> Past <input type="checkbox"/> Now – HIV Virus (AIDS)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lyme Disease
<input type="checkbox"/> Past <input type="checkbox"/> Now – Meningitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Attention Deficit	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hyperactivity

<input type="checkbox"/> Past <input type="checkbox"/> Now – Learning Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dyslexia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Developmental Delay
<input type="checkbox"/> Past <input type="checkbox"/> Now – Depression	<input type="checkbox"/> Past <input type="checkbox"/> Now – Tension/Anxiety Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Post Traumatic Stress
<input type="checkbox"/> Past <input type="checkbox"/> Now – Physical Abuse	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sexual Abuse	<input type="checkbox"/> Past <input type="checkbox"/> Now – Anorexia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bulimia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Migraine Headache	<input type="checkbox"/> Past <input type="checkbox"/> Now – Epilepsy (Seizures)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Nearsighted	<input type="checkbox"/> Past <input type="checkbox"/> Now – Farsighted	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wears Glasses
<input type="checkbox"/> Past <input type="checkbox"/> Now – Lazy Eye	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blindness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Deafness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Wears Hearing Aid	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Ear Infections	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hay fever/Allergy
<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Sinus Infection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nose Polyps	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dental Problems
<input type="checkbox"/> Past <input type="checkbox"/> Now – Mouth Ulcers/Sores	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Tonsils	<input type="checkbox"/> Past <input type="checkbox"/> Now – Congenital Heart Disease
<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Rhythm Problems	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Murmur	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mitral Valve Palpitations
<input type="checkbox"/> Past <input type="checkbox"/> Now – Other Hrt. Valve Problems	<input type="checkbox"/> Past <input type="checkbox"/> Now – Asthma	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Bronchitis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Pneumonia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Tuberculosis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Acid Reflux Stomach
<input type="checkbox"/> Past <input type="checkbox"/> Now – Stomach Ulcer	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lactose Intolerance	<input type="checkbox"/> Past <input type="checkbox"/> Now – Colitis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Crohn's Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Celiac Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Irritable (Spastic) Bowel
<input type="checkbox"/> Past <input type="checkbox"/> Now – Jaundice	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hernia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hepatitis A
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hepatitis B	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hepatitis C	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dysentery
<input type="checkbox"/> Past <input type="checkbox"/> Now – Parasites	<input type="checkbox"/> Past <input type="checkbox"/> Now – Giardia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Candida
<input type="checkbox"/> Past <input type="checkbox"/> Now – Worms	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bladder Infection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Kidney Infection
<input type="checkbox"/> Past <input type="checkbox"/> Now – Urethral Stricture	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginitis (Yeast)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginitis (Other)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Venereal Disease (VD)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscular Dystrophy	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rheumatoid Arthritis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Lupus (SLE)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bone Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sciatica
<input type="checkbox"/> Past <input type="checkbox"/> Now – Whiplash	<input type="checkbox"/> Past <input type="checkbox"/> Now – Eczema	<input type="checkbox"/> Past <input type="checkbox"/> Now – Atopic Dermatitis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Psoriasis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Seborrhea	<input type="checkbox"/> Past <input type="checkbox"/> Now – Athletes Foot
<input type="checkbox"/> Past <input type="checkbox"/> Now – Ringworm	<input type="checkbox"/> Past <input type="checkbox"/> Now – Diabetes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hypoglycemia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Weight Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hyperthyroidism (High)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hypothyroidism (Low)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Adrenal Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Anemia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sickle Cell Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Thalassemia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hemophilia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Transfusion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Immune Deficiency	<input type="checkbox"/> Past <input type="checkbox"/> Now – Leukemia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Lymphoma	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cancer or Tumor	

List any other past or present illnesses: _____

Please list **handicaps/disabilities**: _____

If you were ever **hospitalized** for at least one overnight stay (but did NOT involve surgery or child birth), please describe: _____

OPERATIONS/SURGERIES: Please list your major operations, including same day surgery. List the name of operation, date it occurred, your age, the reason for the operation, name of the hospital, city and state, and any complications (include any anesthesia reactions). Start with early childhood and list in order to the most recent:

<u>Operation</u>	<u>Date</u>	<u>Age</u>	<u>Reason/Complication</u>	<u>Hospital</u>
Ex: Tonsillectomy	02/20/1962	5	Recurrent Sore Throats	Shriners
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

INJURIES: List any past injuries you have had (not including those stated in the current problem section). Include the typo of injury (car accident, fall, broken bones, machinery/occupation accident, etc.), the date it occurred, your age, and any treatment given. Please list from oldest injury to most recent.

<u>Injury</u>	<u>Date</u>	<u>Age</u>	<u>How Injury Occurred</u>	<u>Treatment Given</u>
Ex: Neck Sprain	02/20/1956	20	Car Accident	Chiropractic
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HEALTH CARE MAINTENANCE: Please list when you last had the following tests, date, age, location and the result if known:

<u>Test</u>	<u>Date</u>	<u>Result</u>
Dental Exam	_____	_____
Hearing Test	_____	_____

<u>Test</u>	<u>Date</u>	<u>Result</u>
Eye Exam/Vision Test	_____	_____
Cholesterol	_____	_____
Tuberculosis (TB) Test	_____	_____

IMMUNIZATIONS: Please list the date and age of any immunization or vaccine you have received and any reaction you may have had (you may bring list on separate sheet from another’s physician’s office if available):

<u>Immunization</u>	<u>Date</u>	<u>Reaction</u>	<u>Immunization</u>	<u>Date</u>	<u>Reaction</u>
DTaO#1	_____	_____	MMR#1	_____	_____
DTaO#2	_____	_____	MMR#2	_____	_____
DTaO#3	_____	_____	PCV(Pneumoccal)#1	_____	_____
DTaO#4	_____	_____	PCV(Pneumoccal)#2	_____	_____
DTaO#5	_____	_____	PCV(Pneumoccal)#3	_____	_____
Tetanus Booster (DT)	_____	_____	PCV(Pneumoccal)#4	_____	_____
Hib (H.flu)#1	_____	_____	Chickenpox #1	_____	_____
Hib (H.flu)#2	_____	_____	Chickenpox #2	_____	_____
Hib (H.flu)#3	_____	_____	Meningococcal	_____	_____
Hib (H.flu)#4	_____	_____	Last Flu shot	_____	_____
Hepatitis B#1	_____	_____	Others:	_____	_____
Hepatitis B#2	_____	_____	_____	_____	_____
Hepatitis B#3	_____	_____	_____	_____	_____
Polio #1	_____	_____	_____	_____	_____
Polio #2	_____	_____	_____	_____	_____
Polio #3	_____	_____	_____	_____	_____
Polio #4	_____	_____	_____	_____	_____

FAMILY HISTORY: Family background may be related to medical conditions. Please fill in all of the following chart to the best of your ability, you may wish to call certain relatives for information if needed. State their first name, mark if they are deceased (X), the age they died, their ethnic background (of your grandparents and parents), cause of death and lastly any medical conditions or illnesses they have had or currently have. You may wish to refer to the list of medical illnesses on previous pages to see if any apply to your family history. Be sure to include genetic or birth defects, mental retardation, or any other unusual disease. You should also include other family members with significant medical history, (Ex. Maternal aunt with breast cancer). Circle all those who live with you now.

<u>Family Member</u>	<u>Name</u>	<u>Deceased</u>	<u>Age</u>	<u>Ethnic</u>	<u>Cause of Death</u>	<u>Illnesses</u>
Example:	Bill	X	72	Hispanic	Heart Attack	High Cholesterol, Diabetes, Cancer, Prostate, etc.
Mother's Mother	_____	_____	_____	_____	_____	_____
Mother's Father	_____	_____	_____	_____	_____	_____
Natural Mother	_____	_____	_____	_____	_____	_____
Father's Mother	_____	_____	_____	_____	_____	_____
Father's Father	_____	_____	_____	_____	_____	_____
Natural Father	_____	_____	_____	_____	_____	_____
Brothers & Sisters: start With the oldest And include Yourself, place A * next to Your name. Do not list Your illnesses, Just those of Your family Members.	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

SOCIAL HISTORY:

Second Hand Smoke: No exposure Child is exposed to second hand smoke, where? _____

Education/School: Public School Private School Home Schooled

What grade is your child currently in our just completed? _____

At what age did your child start school? _____

How well do you feel your child does in school: Very Well Well Fair Poorly Does not apply

How well does your child like school? Very Well Well Fair Poorly Does not apply

How well satisfied are you with the school? Very Well Well Fair Poorly Does not apply

Any problems your child has at school, explain: _____

Religious Affiliation/Denomination: _____

Home Life: Are there any problems at home that concern you? Please explain: _____

Discipline: The following types of discipline are used to change this child's behavior (check all that apply):

- Time Out Remove/limit favorite activity Use bribes Spanking
 Spanking with paddle, belt or other object Yell and scream

Other: _____

How many times in a day do you **say "No"** or "bad" to this child? _____

How many times in a day you **say "Yes"**, "good" or "well done" to this child? _____

Are there any questions or concerns you have about your child's behavior or your methods of discipline?

Hobbies/Play Activities & Exercise:

How well does he/she get along with friends? Very Well Well Fair Poorly Does not apply

How well does your child play with others? Very Well Well Fair Poorly Does not apply

How well satisfied are you with the school? Very Well Well Fair Poorly Does not apply

Does he/she belong to any organizations (i.e. Boy Scouts/Girl Scouts, church group, band) etc:

If he/she likes books and/or movies, what are the favorites? _____

Who is your child's favorite TV, book or movie character? _____

Is there interest or skill in artistic activities? _____

Any sports involvement? _____

Other exercise programs: _____

Personal Habits:

Seven Day Food/Diary Intake: On the following page please list everything you eat and drink for 7 days or as many as you can before your appointment:

Day	Breakfast	Lunch	Dinner	Snacks
Ex	Coffee, 2 cups w/cream, sugar, 2 donuts, 8 oz glass milk	Big Mac, 32 oz. Pepsi Large French Fries Salad w/ranch dressing 1 can Pepsi mid-afternoon	1 soy burger Brown Rice Fresh Green Beans Olive Oil on green beans	1 bag Doritos 5 sticks gum 1 bag popcorn 8 oz. tap water 8 oz. spring water
1				
2				
3				
4				
5				
6				
7				