ADVANCED HEALTH
Wellness Center

PEDIATRIC HISTORY

Date_____ **Referred By**_____

Patient Name_____ **Phone Number**_____

Address_____

City_____ **State**_____ **Zip**_____

Birth Date_____ **Sex**_____ **Weight**_____ **Height**_____

Names of Parents/Guardians_____

Purpose for Contacting Us? _____

Other doctors seen for this condition_____

Treatment_____

Check any of the following that pertains to your child:

☐ Ear Infections	☐ Digestive Problems	☐ ADHD	☐ Temper Tantrums
☐ Asthma	☐ Bed Wetting	☐ Auto Accident	☐ Headaches
☐ Allergies	☐ Seizures	☐ A Fall	☐ Chronic Colds
☐ Colic	☐ Recurring Fevers	☐ Traumatic Birth	☐ Adverse Vaccination
☐ Scoliosis	☐ Constipation	☐ Diarrhea	☐ Reaction

☐ Other_____

Family History_____

Name of Pediatrician_____ **Date of Last Visit**_____

Reason_____ **Treatment**_____

Number of Doses of antibiotics your child has taken:

1) **In the last 6 months:**_____
2) **Total during his/her life:**_____

Number of doses of other prescription medications your child has taken:

1) **During the last 6 months:**_____
2) **Total during his/her life:**_____

Vaccination History: (List Vaccines and When Given)_____

_____

_____

Feeding History:

☐ Breast-fed If yes, how long?_____ ☐ Formula If yes, how long?_____

Introduced solids at_____months. Cow's milk at _____months.

ADVANCED HEALTH
Wellness Center

PEDIATRIC HISTORY

Prenatal History:

___Complications during pregnancy? Explain_____

___Ultrasounds during pregnancy? How many?_____

___Medications during pregnancy/delivery? List them_____

___Cigarette/alcohol use during pregnancy? Frequency_____

Location of Birth ___*Hospital* ___*Home* ___*Other*_____

Birth Intervention ___*Forceps* ___*Vacuum Extraction* ___*C-Section*

Delivery Complications? ___*No* ___*Yes*

*If Yes - Explain*_____

Birth Weight_____ **Birth Length**_____ **APGAR Scores**_____

***Childhood Diseases*:**
___Chicken Pox Age:____ ___Rubella Age:_____ ___Whooping Cough Age:____
___Rubeola Age:____ ___Mumps Age:_____ ___Other_____

Developmental History:
At what age was your child able to:

Respond to sound _____ Crawl _____ Sit _____ Stand Alone_____

Respond to visual stimuli _____ Hold head up _____ Walk Alone_____

Has your child ever been involved in a car accident? ___**No** ___**Yes**

If Yes - Explain_____

Has your child ever fallen? ___**No** ___**Yes**

If Yes – Explain_____

Prior Surgery? ___**No** ___**Yes**

If Yes - Explain_____

I hereby authorize Advanced Health and Wellness Center, Inc. to administer care to my son/daughter. I clearly understand and agree that I am personally responsible for payment in full at this time.

Signed_____ **Date**_____

Relationship to Patient_____