Jennifer C. Reid, N.D.
27530 SE Division Dr, Bldg C, Gresham, OR 97030
Ofc (503)492-9427 Fax (503) 492-7958
E:mail jen@favoritedr.com Web site http://favoritedr.com

Pediatric health history

Name:_____ Birth date:_____ Age:____

Mother's name_____ Father's Name_____

Siblings (and ages)_____

_____

What is the reason for this visit?_____

Who are your main caretakers?_____

What pets live with you-indoors or/and outdoors_____

_____

_

When and where have you traveled outside the country?_____

What is your religion and how important is religion/spirituality in your family's life? _____

_____

What is your favorite toy/object?_____

Is there something else I should know about you?_____

_____

_____

_____

___

Perinatal:

	YES	NO
Very active before birth		
Hospital or birthing center		
Needed newborn special care		
Appeared healthy		
Easily consoled during first month		
Antibiotics during first month		
No complication first month of life		

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Birth weight and Apgar:

Weight at birth:	Apgar at one minute:	Apgar at 5 minutes:

Early childhood illnesses:

Number of ear infections in the first 2 years:	
Number of other infections in the first 2 years	
How many times on antibiotics in the first 2 years?	
Any prophylactic antibiotics in first 2 years?	
First antibiotic at _____ months	
First illness at _____ months	

Description of developmental problems:

Are there developmental problems? Yes____ No ____ Explain _____

_____

_

At what age did the problems appear? _____

Is this impression shared by others caring for your child? (doctors, caretakers, friends etc) _____

Is there a strong impression as to when the problem started? _____--

Developmental history:

Please indicate the approximate age in months for the following milestones:

Sitting up		First words	
Crawling		Spoke clearly	
Pulled to stand		Ate solid food (what was it)	
Potty trained			
Dry at night		*Lost language*	
Walked alone		*Lost eye contact*	

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Please check if any symptoms apply currently. If the problem was present in the past, put a "P" in the comment row.

Symptom	**comment**
Enlarged lymph nodes, neck	
Enlarged lymph nodes, elsewhere	
Lymph nodes tender	
Overweight	
Underweight	
Pupils unusually large	
Pupils unusually small	
Dark circles under eyes	
Unusual long eyelashes	
Webbed toes	
Sensory:	
Unusually fearful	
Unaware of danger	
Unaware of peoples feelings	
Very sensitive to pain	
Bothered by certain sounds	
Ear pain	
Ear ringing	
Hearing acute	
Hearing loss	
Sensitive to loud noise	
Covers ears with sounds	
Excessive ear wax	
Likes head pressed hard or rubbed	
Intensely aware of odors	
Sniffs things (magazines, pens…)	
Hates wearing shoes	
Insensitive to pain	
Blinking	
Bothered by bright lights	
Fails to blink at bright light	
Likes flickering lights	
Poor vision	
Strabismus (crossed eye)	
Adopts complicated rituals	
Collects particular things	
Draws only certain things	
Fixated on one topic	
Lines objects up precisely	
Repeats phrases, sentences	
Repetitive play	
Upset if things change	

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Behavior	
Aloof , indifferent, remote	
Behavior is purposeless	
Bites or chews fingers	
Bites hands	
Constant movement	
Curious, gets into things	
Destructive	
Extremely cautious	
Head banging	
hyperactive	
Melt downs	
Poor focus, attention	
Silly	
Toe walking	
Uninterested in pet	
Mean to pets	
Unusual play	
Teases others	
Tries to control others	
Unable to predict actions	
Poor eye contact	
Finger flicking	
Flaps hands	
Jumps when pleased	
Licking	
Likes spinning objects	
Rhythmic rocking	
Sits and stares	
Tooth tapping	
Looks out of sides of eyes	
Lacks initiative	
Headaches	
Joint pain	
Leg pain	
Muscle pain	
General	
Perspiration has odd odor	
Sweats when sleeping	
Feet stinky	
Physically awkward	
Seizures	
Stiffens body when held	
Unusual sound of cry	
Abnormal fatigue	
Moaning	

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Conjunctivitis	
Eye crusting	
Lid margin redness	
Heart murmur	
Mitral valve prolapse	
Unusually fast heart beat	
Cheek/ear – pink/cold	
Cold all over	
Cold hands and feet	
Cold intolerance	
Hands/feet sweaty	
Night sweats	
Tip nose – pink/cold	
Communication	
Does not ask questions	
Poor expressive language	
Points to objects but can't name	
Receptive language poor	
Talks to self	
Anxiety	
Inconsolable crying	
Negative	
Phobias	
Severe mood swings	
Sleep	
Awakens screaming	
Awakes at night	
Difficulty falling asleep	
Nightmares	
Sleepwalking	
Sleeps more/less than normal	
Digestion/food	
Pica (eats indigestible things)	
Always thirsty	
Behavior worse with food	
Bingeing	
Bread craving	
Craves carbohydrates	
Craving for juice	
Craving for salt	
Diet soda craving	
Poor appetite	
Abdominal bloating	
Abdominal pain	
Burping	

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Colic	
Constipation	
Cracking in corners of lips	
Diarrhea	
Passing gas	
Passing gas – very stinky	
Rectal fissure	
Geographic tongue (map like)	
Gums bleed	
Intestinal parasites	
Cold sores	
Thrush	
Nausea	
Red ring around anus	
Reflux	
Sore throat	
Stools bulky	
Stools very stinky	
Stool with blood	
Stools with mucous	
Stool with undigested food	
Teeth grinding	
Vomiting	
respiratory	
Bad odor in nose	
Breath holding	
Bronchitis	
Congestion at change of season	
Congestion in fall	
Cough	
Pneumonia	
Post nasal drip	
Sighing	
Sinus fullness	
Wheezing	
Yawning	
Skin	
Acne	
Athletes foot	
Blotchy skin	
Bugs love you	
Cellulite	
Chicken skin	
Birth marks	
Diaper rash	

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Ears get red	
Easy bruising	
Eczema	
Flushing	
Odd body odor	
Oily skin	
Red face	
Psoriasis	
Vitiligo	
Itching	
Anus	
Arms	
Ear canals	
Eyes	
Feet	
Nose	
Penis	
Scalp	
Vagina	
Skin in general	
Hair, skin, nails	
Dry hair	
Dry skin	
Feet cracking	
Lackluster skin	
Bites nails	
Nail fungus	
Thickening of nails	
White spots on nails	
Muscular	
Muscle cramps	
Muscle pain	
Muscle tone tense/ clenching	
Muscles twitch	
Poor muscle tone/limp	
Tics	
Numbness or tingling of extremities	
Reproductive	
Girls: age of first period	
Boys: undescended testicle	
Early breast development	
Early onset pubic hair	
Urinary	
Bedwetting after age 4	
Odd urinary odor	
Urinary hesitancy	

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Urinary tract infections	
Urinary urgency	
pallor	

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Biological mother's history

Age of mother at child's birth_____ Age of father at child's birth_____

Mothers number of pregnancies_____ births_____ miscarriage_____

Please check if any of the following occurred **during the birth mothers pregnancy and describe**	
Difficulty getting pregnant (>6mo)	
Infertility drugs used	
In vitro fertilization	
Drink alcohol	
Smoke tobacco	
Take progesterone	
Take prenatal vitamins	
Take antibiotics	
Take other drugs	
Excessive vomiting, nausea >3 weeks	
Have a viral infection	
Have a yeast infection	
Have amalgam fillings put in teeth	
Have any amalgams removed from teeth	
How many fillings in teeth during pregnancy	
Have bleeding (which months)	
Group B strep infection	
C- section	
Use pitocin for labor	
Have an x-ray	
Have Rhogam, how many?	
High blood pressure	
Have house exterminated	
Have house painted	
Total weight gained in pregnancy	
Chemical exposure	

Please bring a list with all supplements and/or medication your child is currently taking:

Thank you for taking time to fill all of this out!

This detailed information helps in making the best decisions in the health care of your child.