

Wyndgate Health

970 Raymond Ave., Ste. 101
 St. Paul, MN 55114
 651-493-4566 / Fax: 651-344-0429

Initials: Appointment:
Date:
BP:
Pulse:
For office use only

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All information in this Health History is strictly confidential and will become part of the patient's permanent medical record.

Patient Name:											
Patient Home Address:											
Referred to Wyndgate by whom?											
Gender:	Male		Female		Date of Birth:		Age:				
Parent Names:											
Home Phone:						Cell Phone:					
Work Phone:						Email:					
With whom does the child live?											
Health History											
Weight:		Height:		Year your home was built?							
Immunizations?		Yes		No	Regression?		Yes		No		
Second-hand smoke exposure?		Yes		No							
Smoker or other use of tobacco?		Yes		No							
Use of non-prescription drugs?		Yes		No							
Use of alcohol?		Yes		No							
Known medical problems:											
Gestational age at birth?											
For what three symptoms are you bringing your child to Wyndgate Health?											
1.											
2.											
3.											
When did you first notice the above?											
The onset of these symptoms was...		Sudden		Gradual							
Child is adopted and without a family health record.		Yes		No							

Pediatric Health History, Wyndgate Health

Surgeries & Hospitalizations							
Date:	Surgery Type:	Outcome:	Comment:				
Child's Current Medications							
Med. Name:	Dose:	Per Day:	Date Started:	Comment:			
Medication Allergies							
Medication:	Reaction:						
Current Supplements							
Name:	Dose:	Per Day:	Date Started:				
Known Food Allergies							
Food:	Reaction:						
Sensitivities							
	Perfume		Detergents		Mold		Dogs
	Cosmetics		Dust		Pollens		Cats
	Soaps		Fungus				

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Sensitivities (continued)										
	Gasoline		Other:							
List any familial occupational chemical exposures:										
Health Habits										
Bowel Habits:		Number of Bowel Movements per Day?					per Week?			
Constipation				Formed Stools						
Diarrhea				Loose Stools						
Excessive Gas				Stomach Aches						
Toilet trained?			No		Yes					
If Yes, trained for...			Stool & Urine		Stool only		Urine only			
Does your child have encopresis?					Yes		No			
Has child had any testing or treatments for the gut?					Yes		No			
If Yes, please explain:										
Dietary Habits										
Is your child on a special diet?			Yes		No					
If Yes, please explain:										
Average number of daily meals?				Average Number of Daily Snacks?						
What is the primary source of water consumption?										
Tap Water		Well Water			Bottled Water			Filtered Water		
Have you had your water tested?				Yes		No				
If Yes, what were the results?										
Servings or cups per day of following:										
Protein		Sweets			Carbohydrates					
Dairy		Fruits			Vegetables					
Coffee		Tea			Cola					
Colic or formula intolerance?			Yes		No					
Breast fed?			Yes		No					
If Yes, how long?										

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Sleep Habits					
Does your child have difficulty:					
	Falling asleep		Staying asleep		Waking up
Does your child experience:					
Dream recall:		Sometimes		Vivid	None
Sleep walking:		Sometimes		Regularly	None
Sleep talking:		Sometimes		Regularly	None
Family Health History					
<i>Use Below Relative Codes to indicate who in the family has experienced any of these health issues.</i>					
Health Issue	Relative Code		Health Issue	Relative Code	
ADD / ADHD			Bipolar disorder		
Alcohol abuse			Cancer		
Anxiety			Depression		
Arthritis			Diabetes		
Asthma			Eczema		
Food allergies			Stroke		
Heart disease			Suicide attempts		
High blood pressure			Thyroid		
Memory issues			Ulcers		
Psoriasis			Violence / criminal		
Psychosis					
Relative Codes for Use Above					
Code	Definition	Code	Definition	Code	Definition
M	Mother	MA or MU	Maternal Aunt / Uncle	MGM or MGF	Maternal grandmother / grandfather
F	Father	PA or PU	Paternal Aunt / Uncle	PGM or PGF	Paternal grandmother / grandfather
S	Sister				
B	Brother				
Mother's Prenatal History					
Mother's age at delivery:					
Illnesses during the pregnancy:					
Vaccines during the pregnancy:					
Medications used during the pregnancy:					

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Mother's Prenatal History (continued)				
Complications during the pregnancy:				
Complications during labor and delivery:				
Medications used during the delivery:				
Mother had dental work during pregnancy or breast feeding?			Yes	No
Delivered by:	Vaginal	C-section	Forceps / vacuum	
Child's Mental Health				
If you answer Yes, please explain or describe.				
Yes	No	Anxiety disorder		
Yes	No	Anger		
Yes	No	Behavior		
Yes	No	Sensory		
Yes	No	Depressive disorders		
Yes	No	Autism, ADHD		
Yes	No	Eating disorders		
Yes	No	Mood disorders		
Yes	No	Psychotic disorders		
Racing thoughts		Easily distracted		Learning disabilities
"Foggy" brain		Intrusive thoughts		Mood swings
Family Life, Social History				
Recent life changes or stressors?				
Recent travel? If so, where?				
Any adopted children in family?				
List most important people in child's life.				
Active in sports, music, etc., activities?				
How does your child interact with other children?				
How does your child interact with adults?				
What makes your child happy?				

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Family Life, Social History (continued)									
What makes your child sad?									
What makes your child angry?									
What makes your child stressed?									
FEMALES ONLY: Age of menstruation onset age?									
FEMALES ONLY:		PMS		Excessive cramping		Excessive bleeding			
Developmental History									
Language development		Early		Normal		Late		None	
Language regression		Yes		No		If yes, age?			
Language development		Echolalia		Scripting		Able to understand		Follow directions	
Receptive age?					Expressive age?				
Age to begin to walk?									
Age to begin to dress themselves?									
Age to begin appropriate play?									
Has your child received any developmental therapies? If so, please describe.					Yes		No		
Signs & Symptoms									
For signs or symptoms your child exhibits, check one box that best describes the severity of the symptom. If the symptom does not apply to your child, leave blank.									
Item	Description	Mild	Moderate	Severe	Details				
0	Poor eye contact								
1	Stimming (repetitive actions)								
2	Rocking								
3	Head banging								
4	Self-mutilation								
5	Nail biting								
6	Hand / arm biting								
7	Nail / skin picking								
8	Aggressiveness								
9	Irritability / tantrums								
10	Fears / anxiety								
11	Hyperactivity								
12	Lack of concentration								
13	Fidgets in seat								
14	Impulsiveness								
15	Breath holding								

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Signs & Symptoms (continued)					
Item	Description	Mild	Moderate	Severe	Details
16	Dizziness				
17	Seizures				
18	Poor balance				
19	Problem w/ zippers, buttons, snaps				
20	Visual, motor, language processing problems				
21	Socialization problems				
22	Sensitive in crowds				
23	Memory problems				
24	Low self esteem				
25	Fatigue				
26	Cold hands / feet				
27	Heat intolerant				
28	Chronic fevers				
29	Flushing				
30	Difficulty falling asleep				
31	Night walking				
32	Nightmares				
33	Difficult to wake				
34	Bed wetting				
35	Bed soiling				
36	Daytime wetting				
37	Daytime soiling				
38	Headache				
39	Blinking				
40	Involuntary tics				
41	Eye discharge				
42	Under eye "shadows" / puffiness				
43	Numbness, tingling hands or feet				
44	Nasal congestion				
45	Dripping nose				
46	Earaches				
47	ringing in ears				
48	Sound sensitivity				
49	Bad breath				
50	Nose bleeds				

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Item	Description	Mild	Moderate	Severe	Details
51	Strong sense of smell				
52	Sore throats				
53	Hoarseness				
54	Cough				
55	Wheezing				
56	Frequent colds / infections				
57	Bumpy tongue				
58	Swollen neck glands				
59	Canker sores				
60	Dry lips / mouth				
61	Diarrhea				
62	Constipation				
63	Bloating				
64	Passing gas				
65	Belching				
66	Stomach aches				
67	Refusal to eat				
68	Food texture sensitivities				
69	Food cravings				
70	Teeth grinding				
71	Mucous / blood in stool				
72	Undigested food in stool				
73	Anal itching				
74	Calf cramps				
75	Tremors				
76	Weakness				
77	Stiffness				
78	Eczema				
79	Psoriasis				
80	Hives				
81	Acne				
82	Seborrhea				
83	Rashes				
84	Easily bruised				
85	Itchy scalp				
86	Dry skin				
87	Oily skin				
88	Pale skin				
89	Insect bite sensitivity				
90	Cracking / peeling hand skin				
91	Cloth texture sensitivity				
92	Cracking / peeling foot skin				

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93	Strong body odor				
94	String urine odor				
95	Strong stool odor				
96	Soft nails				
97	Thickening nails				
98	Nail ridges / pitting				
99	Brittle nails				
100	Nail white spots				
101	Holds pressure on stomach				
102	Thrush				
103	Poor muscle tone				
104	Staring episodes				
105	Any OCD behavior				
107	Gastric reflux				
108	Persistent colic				
109	Toe walking				
110	Yeast infections				

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