

COMPREHENSIVE PEDIATRIC MEDICAL HISTORY

Confidential Medical Record – Unauthorized Use Strictly Prohibited

Confidential Patient Information

Patient Name		Date	
Street Address		City/State	Zip Code
Guardian Home Phone ()	Guardian Work Phone ()	Guardian Cell Phone/Pager ()	
Email Address	Date of Birth	Current Age:	Years Months
Social Security #		Method of Payment	

Mothers Name:	Father's Name:
Legal Guardian:	Other:

Patient's Personal Physician:	Type of Doctor:	
Doctors Phone #:	Date of Child's Last Exam:	Diagnosis:

Insurance Information:

Name or Insurance Company	Billing Address	Policy # and Subscriber
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Referred by:

<input type="checkbox"/> Patient Name:	<input type="checkbox"/> Physician Name	<input type="checkbox"/> Other
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I hereby give Dr. Andrew Gregory permission to release my records to my other doctors and to my health insurance company, including psychiatric, substance abuse and AIDS related information. Further, I hereby acknowledge that I have been given access to, and reviewed, a copy of the practice PRIVACY POLICY and I understand that I may contact the office manager if I have any further questions or complaints and that I am entitled to receive a written copy of these policies at my request. I also understand that I am entitled to receive updates upon request if the PRIVACY POLICY is amended or changed in a material way.

Guardian Signature _____ Date: _____

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Dr. Andrew Gregory, and whomever he may so designate as his assistant, to administer care as he deems necessary to my son/daughter, _____, dated at South Windsor, CT this _____ day of _____, 20____.	
Signature:	Witnessed:

IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:		
Home Phone	Work Phone	Cell Phone

PERSONAL HISTORY

Height	Ft.	Inches	Weight	Lbs.	Percentile Rank
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Current School Grade: _____ Private School Public School N/A Other

Academic Performance: Not in School Remedial/Special Ed Below Average Average Above Average

Number of weeks gestation: Pre-term # of weeks _____ Full term (38-40 wks) Post term - # of weeks _____

Birth by: NSVD VD-induced C-Section Complications: No Yes Explain _____

Birth Weight: _____ lbs _____ oz. Apgar Score: _____ / _____

Was child breast fed? Yes # of months _____ No Formula/Type: _____

At what age was child introduced to solid foods? _____ Any negative reactions? No Yes _____

Estimate courses of antibiotics during 1st year of life: _____ Total since birth: _____

Does child have a tendency toward constipation? No Yes Sometimes

How many bowel movements a day on average? 1 or less 1 2 3 Greater than 3

Does child have undigested food in stool? No Occasionally Often Always

Immunizations: None Some All immunization up-to-date for age

Did child have reaction(s) to any immunizations? No Yes Explain: _____

At what age did child first walk? _____ Precocious Average Delayed Other _____

Motor skills are considered? Precocious Average Delayed Other _____

Speech is considered? Precocious Average Delayed Other _____

How many hours/night does child sleep on average? 4-5 6-7 7-8 9-10 10+ Is sleep disturbed? No Yes

Rate the quality of sleep? 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
(Poor) (Average) (Excellent)

Does child have night terrors? Never Rarely Sometimes Often

Does child have dark circles under eyes? No Occasionally Often

Does child have any unexplained rashes or itching, especially in the ears, groin or belly button? No Sometimes Often

Does child have a chronic whitish or brown coating on tongue that cannot be brushed off? No Yes

Does child have little bumps, pimples or scaly skin on the back of their arms? No Not sure Yes

Does child have dry skin or eczema? No Sometimes Yes

Does child seem to have excessive thirst? No Sometimes Yes

Does child seem “addicted” to sugars, sweets and carbohydrates? No Sometimes Often

Does child get headaches after eating sugar, bread, pasta, fruit, or cereal? Never Sometimes Often

Has child’s language skills seem to have regressed? No Possibly Yes

Does child point to objects? Yes No

Does child seem to avert eye contact? Yes No

Does child avoid or fear strangers? No Rarely Yes

MATERNAL HISTORY

Age of mother at pregnancy? _____ # Pregnancy: First Second Third Fourth Other _____

Did mother have any medical problems PRIOR to pregnancy? _____

Did mother smoke during pregnancy? No Yes # per day _____

Did mother drink alcohol during pregnancy? Never Yes Type: Wine Beer Liquor # drink/wk _____

Maternal complications during pregnancy? None High blood pressure Edema Diabetes Pre-eclampsia Eclampsia

Did mother take any medications or drugs during pregnancy? No Yes Type and amount: _____

Rate mothers stress level during pregnancy Mild Moderate Severe

Has CHILD (not a family member) EVER been diagnosed with

ADD or ADHD	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Allergies/Hayfever	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Asperger's syndrome (AS)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Asthma	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Anemia	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Autism	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Bladder/Urine Infection (UTI)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Blood Pressure Problems	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Bronchitis/Pneumonia	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Colitis/Crohn's Disease	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Croup	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Cystic Fibrosis	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Developmental Delay	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Diabetes Type I (Juvenile Diabetes)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Dysentery/Food Poisoning	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Dyslexia	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Ear Infection (Otitis Media)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Easy Bruising	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Eating Disorder	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Eczema/Psoriasis – Skin Problems	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Enlarged Heart	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Epilepsy (Seizures)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Gastric Reflux or Ulcers	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Goiter	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Heart Arrhythmia	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Heart Murmur	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Heavy Metal Poisoning	<input type="checkbox"/> Never		<input type="checkbox"/> Yes:	_____
Hemochromatosis (Iron Overload)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Hepatitis/Jaundice	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	<input type="checkbox"/> Hep A <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C
Hives	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Hyperthyroidism	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Hypothyroidism	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Irritable Bowel (IBS)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Juvenile Rheumatoid Arthritis	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Kidney Infection	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Kidney Stones	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Learning Disorder	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Lyme Disease	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Meningitis	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Mental Retardation	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Migraine Headaches	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Mononucleosis	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Multiple Sclerosis (MS)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Pervasive developmental disorder	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Pharyngitis	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Sinusitis	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Speech Delay	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Strep Throat	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Syphilis/Chlamydia/STD	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Tourette's	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Yeast Infections	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Yes:	_____
Other	_____			
Other	_____			
Other	_____			

ALLERGIES: Is child allergic to ANY of the following?

Penicillin/Amoxicillin	No	Yes	Describe	_____
Sulfa Drugs (Bactrim)	No	Yes	Describe	_____
Mycias (Erythomygia)	No	Yes	Describe	_____
Other Antibiotics	No	Yes	Describe	_____
ANY OTHER MEDICATIONS	No	Yes	Describe	_____
Iodine or Radiologic Dye	No	Yes	Describe	_____
Perfumes	No	Yes	Describe	_____
Cosmetics	No	Yes	Describe	_____
Latex (Hospital gloves)	No	Yes	Describe	_____
Grasses, Trees, or Pollen	No	Yes	Describe	_____
Molds	No	Yes	Describe	_____
Dust	No	Yes	Describe	_____
Household Cleaning Products	No	Yes	Describe	_____
Animals/Dander	No	Yes	Describe	_____
Do you live with any pets?	No	Yes	Describe	_____

Is child SENSITIVE/INTOLERANT/ALLERGIC to any of the following foods?

Milk/Dairy Wheat/Gluten Peanuts Soy Eggs Corn Yeast Chocolate Citrus Fish/Shellfish Strawberries
 Other: _____

ANY other allergies? No Yes Describe _____

Does anyone in the home smoke? Never No Yes Type: Cigarettes Cigars Pipes Other _____ Number/day: _____

IMMUNIZATIONS: Has child been immunized against:

Hepatitis B	No	Yes	Describe	_____
Heamophilis Influenza (HiB)	No	Yes	Describe	_____
Diphtheria/Tetanus/Pertussis (DPT)	No	Yes	Describe	_____
Chicken Pox	No	Yes	Describe	_____
Lyme Disease	No	Yes	Describe	_____
Measles-Rubeola/Mumps	No	Yes	Describe	_____
Rubella-German.Measles	No	Yes	Describe	_____
Polio (OPV)	No	Yes	Describe	_____

MEDICATIONS: Is child currently taking (or recently discontinued) any of the following PRESCRIBED medications?

Antibiotics-Amoxicillin etc.	No	In Past	Yes	Name/Dose	_____
Asthma Medication-Proventil etc.	No	In Past	Yes	Name/Dose	_____
Antidepressants-Prozac/Paxil/Zoloft/Luvox.	No	In Past	Yes	Name/Dose	_____
Blood Thinning Medication (incl. Aspirin)	No	In Past	Yes	Name/Dose	_____
Prednisone-Cortisone	No	In Past	Yes	Name/Dose	_____
Insulin or Diabetes Pills	No	In Past	Yes	Name/Dose	_____
Ritalin (methylphenidate)	No	In Past	Yes	Name/Dose	_____
-Ritalin SR	No	In Past	Yes	Name/Dose	_____
-Detredine/Dexedrine Spansule	No	In Past	Yes	Name/Dose	_____
-Concerta	No	In Past	Yes	Name/Dose	_____
-Metadate CD/Metadate ER	No	In Past	Yes	Name/Dose	_____
-Adderall/Adderall XR	No	In Past	Yes	Name/Dose	_____
-Cylert	No	In Past	Yes	Name/Dose	_____
Secretin	No	In Past	Yes	Name/Dose	_____
Thyroid Hormones-Synthroid etc	No	In Past	Yes	Name/Dose	_____
Sleep Medications	No	In Past	Yes	Name/Dose	_____
Name of any other medications child is <u>currently</u> taking:	_____				

OPERATIONS AND HOSPITALIZATIONS: Has child ever had any of these surgically operated on?

Appendix No Yes Yr/Description _____
Chest No Yes Yr/Description _____
Ears No Yes Yr/Description _____
Eyes No Yes Yr/Description _____
Gall Bladder No Yes Yr/Description _____
Heart No Yes Yr/Description _____
Hernia No Yes Yr/Description _____
Intestine No Yes Yr/Description _____
Kidneys No Yes Yr/Description _____
Knees No Yes Yr/Description _____
Nose No Yes Yr/Description _____
Spleen No Yes Yr/Description _____
Stomach No Yes Yr/Description _____
Tonsils No Yes Yr/Description _____
Thyroid No Yes Yr/Description _____
Any other Hospitalizations? No Yes Yr/Description _____

DEVICES: Does child have any of the following?

Ear Tubes No Yes Date Last Exam _____
Eyeglasses No Yes Date Last Exam _____
Contact Lenses No Yes Date Last Exam _____
Dental Braces No Yes Date Last Exam _____
Back Brace No Yes Date Last Exam _____
Knee Brace No Yes Date Last Exam _____
Neck Brace No Yes Date Last Exam _____
Metal Plate No Yes Date Last Exam _____
Shunt No Yes Date Last Exam _____
Other _____

How is child's dental health? Excellent Good Fair Poor

Has child had EYE exam? No Yes Date Last Exam _____
Has child had HEARING exam? No Yes Date Last Exam _____

TESTS: Has child ever had an X-ray, CAT-Scan, MRI, Sonogram, PET-scan or Bone Scan (circle which test) of:

Head No Yes Yr/Test/Result _____
Sinuses No Yes Yr/Test/Result _____
Neck No Yes Yr/Test/Result _____
Chest/Breast No Yes Yr/Test/Result _____
Abdomen No Yes Yr/Test/Result _____
Kidneys/Bladder No Yes Yr/Test/Result _____
Pelvis No Yes Yr/Test/Result _____
Back No Yes Yr/Test/Result _____
Extremities No Yes Yr/Test/Result _____
Other _____

Has child ever had an Electrocardiogram (EKG) No Yes Yr/Result _____

Has child ever had an Echocardiogram No Yes Yr/Result _____

Has child ever had a Colonoscopy/Sigmoidoscopy or Endoscopy No Yes Yr/Result _____

FAMILY HISTORY: Has any blood relative (NOT CHILD) ever had any of the following?

ADD/ADHD	No	Yes	Relation	_____
Arthritis	No	Yes	Relation	_____
Asperger's Syndrome (AS)	No	Yes	Relation	_____
Asthma	No	Yes	Relation	_____
Autism	No	Yes	Relation	_____
Bleeding Disorder	No	Yes	Relation	_____
Bipolar Disorder	No	Yes	Relation	_____
Cancer	No	Yes	Relation	_____
Developmental Delay	No	Yes	Relation	_____
Diabetes Type I / II	No	Yes	Relation	_____
Emphysema	No	Yes	Relation	_____
Hepatitis B or C	No	Yes	Relation	_____
Hypothyroidism	No	Yes	Relation	_____
Learning Disability	No	Yes	Relation	_____
Mental Illness/Suicide	No	Yes	Relation	_____
Migraine Headaches	No	Yes	Relation	_____
Multiple Sclerosis	No	Yes	Relation	_____
Obsessive Compulsive Disorder (OCD)	No	Yes	Relation	_____
PDD	No	Yes	Relation	_____
Seizure Disorder/Epilepsy	No	Yes	Relation	_____
Speech Delay	No	Yes	Relation	_____
Tourette's Syndrome	No	Yes	Relation	_____

DIET AND NUTRITION: Does child consume any of the following?

Milk/Dairy	No	Rarely	Often	Approx glasses/day	_____
Difficulty digesting Milk/Dairy (Lactose Intolerant)	No	Not Aware	Yes		_____
Wheat/Gluten containing grains/cereals	No	Rarely	Often		_____
Soda/Cola	No	Rarely	Often	Approx glasses/day	_____ Type _____
Juices-Orange/Apple	No	Rarely	Often	Approx glasses/day	_____
Water directly from Tap	Never/Rarely	Sometimes	Mostly		_____
Soy-Containing Foods	No	Occasionally	Often – (Circle)	Soy milk Tofu Soy Protein	Times/Week: _____

How many meals plus snacks per day does child eat on average? 1 2 3 4 5 Graze

Does child eat fruits and vegetables? Frequently Rarely Almost Never

How many times/week does child eat Fish (salmon, mackerel, sardines, herring)? More than 3 Rarely 1 – 2X/Wk Almost Never
 How many times/week does child eat Seafood (shrimp, scallops, clams, lobster)? More than 3 Rarely 1 – 2X/Wk Almost Never

Which Fats/Oils does child consume?

Butter Olive Oil Coconut Oil Flax Oil Safflower Oil Sunflower Oil Peanut Oil Grape Seed Oil Macadamia Oil
 Mayonnaise Margarine Crisco Corn Oil Soybean Oil Canola Oil Essential Fatty Acids/Fish Oil

Is child on any special diet?

Dairy-Free Wheat/Gluten-Free Yeast-Free Feingold Low Carbohydrate High Protein No Special Diet
 Other: _____

What diet type does child primarily consume?

- High Carbohydrate – Bread, pasta, cereal, rice, potatoes, juices, sweets, etc
- High Protein – Meat, fish, fowl, eggs, nuts, etc.
- Vegetarian – No meat at all
- No Special Diet – Large variety of protein, vegetables, and starches (carbohydrates)

Please list the foods that child ate yesterday for:

Breakfast _____
 Lunch _____
 Dinner _____
 Snacks _____
 Other _____

Please list the foods in child's "usual" diet (Please be specific):

Breakfast _____
 Lunch _____
 Dinner _____
 Snacks _____
 Other _____

Name the five foods consumed MOST frequently (Please be specific)

1. _____
 2. _____
 3. _____
 4. _____
 5. _____

List all vitamins, minerals, herbs, amino acids, and nutritional supplements (with dose) child is taking on a regular basis:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Please honestly rate your ability, resources, and desire to make the necessary lifestyle, medical, dietary, supplement, and nutrition commitments and modifications for your child in order to significantly impact the typical "natural" course of current disease or disorder.

- Likely only minor changes
- Likely only moderate changes
- Likely I can make major changes
- I can do almost everything it may take

Please consider this question carefully.

If we were your HEALTH GENIES, what would be your ONE health wish for your child?

Do you freely choose and desire Complementary/Integrative/Alternative treatment(s) for your child's medical condition(s) and understand that along with the significant benefits that can often be achieved there may always be, as with all treatments, some inherent risk? YES NO

To the best of my knowledge all of the above information is true and accurate.

Parent/Guardian Signature: _____

For

Patient: _____ Date: _____

