

Heidi Peterson, ND



Patient Name: _____ Age: _____ D.O.B.: _____

Parent/Guardian's Name: _____

What brings you into the office today?

What are your top health concerns, for the above named child, in order of importance?

General state of health is: Excellent Good Fair Poor

Date of last physical: _____ Date of last dental exam if applicable: _____

Current Medications (including supplements, vitamins, and herbs):

Allergies (drugs, food, chemicals, etc):

Past operations / serious illnesses:

Medical History:

Chicken pox Measles Mumps Rubella Scarlet Fever
 Strep throat Pneumonia Colic Croup Bronchitis
 Tonsillitis Ear Infection Allergies Asthma

Immunization History: number received / number suggested

Diphtheria: /4 Pertussis: /4 Tetanus: /4 Polio: /4
 Hepatitis B: /3 Measles: /2 Mumps: /2 Rubella: /2
 H. Flu: /3

Family Medical History: Please note the diseases each family member has or had, their age at death, and cause of death if known:

Father: _____
Mother: _____
Paternal Grandfather: _____
Maternal Grandfather: _____
Paternal Grandmother: _____
Maternal Grandmother: _____
Siblings: _____

Mother's Pregnancy History:

Age at child's birth: _____
 Bleeding Drug/Alcohol Abuse Hypertension Medications
 Physical Trauma Thyroid Problems Gestational Diabetes

Labor/Delivery History:

Pregnancy length: premature full term post term
Birth weight: _____ Length: _____
Any problems? _____

Feeding History:

Breast Fed? _____ How long? _____
Formula Fed? _____ How long? _____ What type? _____
Solid Foods Introduced? _____ What age Introduced? _____
Food allergies/sensitivities: _____

Describe Child's Typical Daily Diet:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Number of bottles given per day: _____ Number of ounces per bottle: _____