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PEDIATRIC HISTORY

Name _____ Date _____ DOB _____

BIRTH HISTORY

Birth Weight _____ Birth length _____

Due date (or delivered time or # weeks early or late) _____

Problems during pregnancy or delivery _____

Problems after delivery for infant _____

Feeding: Breast formula (check one or both) How long each? _____

Any feeding problems or food allergies? Describe _____

DEVELOPMENT AND SOCIAL HISTORY

Please give ages for the following milestone:

Sat up _____ First tooth _____ Toilet trained _____

Walked _____ First words _____ Short sentences _____

Any problems with speech? _____

Any problems with behavior? _____

School or preschool problems? _____

List family members and ages (mom, dad, brothers, sisters) _____

Who lives with the child (list names of all household members) _____

GENERAL HISTORY

Prior physician or clinic _____

Medicine allergies (describe reaction) _____

Hospitalizations (when and for what) _____

Surgeries (when and what type) _____

Describe major accidents, head injuries, poisonings, stitches, broken bones _____

Current medications (include vitamins, fluoride, over the counter drugs) _____

Last dental checkup _____ Problems? _____

Last physical exam _____ Age at last shot _____ Up to date? _____

Check any that your child has had:

Asthma	Heart murmur	Anemia
Urinary tract infection (bladder)	Chicken pox	Pneumonia
Ear infections (how many _____)	Seizures	Stomach aches
Hepatitis or jaundice	Acne	Headaches
Eczema/skin problems	Hearing problems	Leg or foot problems
Eye problems/glasses	Undescended testicles	
Bedwetting after age 7	Other _____	

FAMILY HISTORY

Check any that a relative has had:

Asthma	Alcoholism/drug abuse	High blood pressure
Bleeding problems	Heart attack	Sickle cell anemia
Seizures	Diabetes	Cancer

Are there smokers in your household? Yes No Who? _____