Raj Patel, M.D.
Medical Options for Wellness
1098 Foster City Blvd., Suite 305
Foster City, CA 94404
(650) 474-2130

Pediatric Health History

Child's Name: _____ DOB:_____ Age: _____
Who referred you? _____

Current Medical Problems

Please list the medical problems for which you came to see the doctor. About when did they begin?

Problems	Date Began

Medications: List all medications your child is on.

_____

Supplements: List all nutritional supplements your child is on.

_____ _____ _____
_____ _____ _____

Allergies and Sensitivities: List all medications, foods, supplements that you suspect your child maybe reacting to and the corresponding symptoms.

Allergic to	Effect	Allergic to	Effect

Family History:

Parents separated or divorced? _____ If yes, are both parents agreeing to treatment? _____
Does the child have any siblings? List names and ages _____
Do any of the siblings have illnesses, diagnoses, conditions? _____

_____

Maternal History: List all health problems in past (i.e. rheumatoid arthritis, allergies, asthma, etc.)

_____
_____

Paternal History: List all health problems in past (i.e. rheumatoid arthritis, allergies, asthma, etc.)

_____
_____

Pediatric Health History

Pregnancy Information:

Describe pregnancy and any complications _____

How many silver amalgams did mom have during pregnancy? _____

Did mom have: Any dental work _____ Gestational Diabetes _____

Flu shots or vaccinations during pregnancy _____ Rhogam shot _____

How often has mom eaten seafood before and during pregnancy? _____

Feeding History:

Breast-fed or bottle. Please describe length and character of feeding _____

_____

Any history of food intolerance _____

When and which foods were introduced (up to first birthday) _____

_____

Describe child's current diet _____

_____

If started on special diet (i.e. GFCF) Describe diet, length and response _____

_____

_____

Does child consume any seafood? _____ What does the child drink? _____

Vaccination History: Include detailed vaccination schedule with dates including any adverse reactions

_____

_____

Has the child ever regressed? (i.e. lost a previously attained milestone such as babbling, pointing to objects, speech, social behavior, etc.) _____

_____

Medical History:

Illnesses _____

_____

Number of antibiotics courses _____ Yeast infections _____

Surgeries _____

_____

Does your child have any of the following symptoms? Check all that apply

Hyper _____ Insomnia _____ Poor Coordination _____ Weak _____

Aggressive _____ Eczema _____ Low Muscle Tone _____ Self-Destructive _____

Diarrhea _____ Abdominal Bloating _____ Constipation _____ Sound Sensitivity _____

Touch Sensitivity _____

Current Therapies:

List all therapies child currently receives _____

_____

Is there anything else you would like to share? _____

_____