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 (ie rheumatoid arthritis, allergies, asthma, etc.)

_____
_____

Paternal History List all health problems in past (ie 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 (ie 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? (ie lost a previously attained milestone such as babbling, pointing to objects, speech, social behavior, etc.)

_____
_____

Medical History

Illnesses _____
_____
Number of antibiotic courses _____ yeast infections _____
Surgeries _____
_____
Does your child have any of the following symptons? Check all that apply
Hyper _____ Insomnia _____ Poor Coordination _____ Weak _____
Aggressive _____ Excema _____ 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? _____
_____
_____