David A. Steenblock, D.O. Inc.
Personalized Regenerative Medicine
187 Avenida La Pata
San Clemente, CA 92673

PEDIATRIC HEALTH HISTORY

Date:

Child's Name: ____ Age: _________________ D.O.B:____________________

Your Name: ____ Relationship to child: _____________________________

Primary Care Provider: ________________________________ Allergies: ____

Present Health Concerns: ____

Medication your child takes daily: _____________________________ Herbs used: ______________________________

PREGNANCY AND NEONATAL

Where was your child born: _____________________________ Is your child: ☐ Biological ☐ Adopted ☐ Stepchild

Medical Problems during pregnancy: ____

Delivery: ☐ Vaginal ☐ Caesarean (why): ________________ Birth weight/length: _____________________________

Was your child premature? ________ Weeks: _____________ Medical problems after birth: ______________________

Was your child breastfed: __________ How Long: _________Feeding/Dietary concerns: _________________________

Sleep problems: ____

INFANCY/CHILDHOOD/ADOLESCENCE

Has your child ever been diagnosed with:

- ☐ Asthma ___________________________________
- ☐ Wheezing or Bronchitis ______________________
- ☐ Seasonal Allergies ___________________________
- ☐ Food Allergies ______________________________
- ☐ Recurrent ear infection ______________________
- ☐ Pneumonia _________________________________
- ☐ Eczema ____________________________________
- ☐ Seizures ______________________________
- ☐ Anemia _______________________________
- ☐ Broken bone ___________________________
- ☐ Depression/Anxiety _____________________
- ☐ Constipation ___________________________
- ☐ Chicken Pox ___________________________
- ☐ Attention Deficit Disorder ________________

Other chronic medical conditions: ____

Has your child ever been hospitalized: ____

Previous surgeries and dates: ____

DEVELOPMENT AND SCHOOL

What age did your child: Sit alone: ________ Walk alone: ________ Say words: ________ Toilet train: __________

If applicable, age of first menstrual cycle: ______________________________

How does your child compare to others of same age: ______________________________

FAMILY HISTORY

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma/Hay fever	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Alcoholism/Drug abuse	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
Inherited/Genetic disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐

REVIEW OF SYSTEMS

Please review the topics below check if concerned for your child:

- ☐ Fevers/Chills/Sweating
- ☐ Unexplained Weight loss/gain
- ☐ Squinting
- ☐ Asymmetric Gaze/Cross Eyed
- ☐ Unusual loud voice
- ☐ Mouth breathing/Snoring
- ☐ Bad breath
- ☐ Frequent runny nose
- ☐ Problems with teeth/gums
- ☐ Coughing/wheezing
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Blood in bowel movements
- ☐ Tires easily
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Bedwetting
- ☐ Developmental concerns
- ☐ Relationship with parents
- ☐ Self-image worth
- ☐ Pain with urination
- ☐ Discharge: penis or vagina
- ☐ Headaches
- ☐ Clumsiness
- ☐ Hay Fever
- ☐ Itchy eyes
- ☐ Rashes
- ☐ Unusual moles
- ☐ Joint pain
- ☐ Speech problems
- ☐ Anxiety/Stress
- ☐ Problems with sleep
- ☐ Depression
- ☐ Nail biting/thumb sucking
- ☐ Depression

Other:

____

____

____