

GENERAL HEALTH HISTORY

4286 Cascade Rd SE Grand Rapids, MI 49546

Patient Name _____ **Mark the conditions that apply to you.**

Past Present

- ☐ Headaches
- ☐ Ear Infections
- ☐ Colic
- ☐ Allergies / Asthma
- ☐ Medication Side Effects
- ☐ Recurring Fevers
- ☐ Digestive problems
- ☐ Bed Wetting
- ☐ Chronic Colds/Sinus
- ☐ Other _____

Past Present

- ☐ Vision Problems
- ☐ Sleeping Problems
- ☐ Growing Pains
- ☐ Dental Problems
- ☐ Temper Tantrums
- ☐ ADHD
- ☐ Seizures
- ☐ Scoliosis
- ☐ Ever Needed Stitches

1. List any medications being

taken: _____

2. Number of courses of Antibiotics child has taken in the last 6 mo. _____ **Total during**
lifetime _____

3. Name of Pediatrician and Other Doctors:

4. Date of Last Visit ____/____/____ **Reason:** _____

5. Name of Obstetrician/Midwife: _____

6. Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

7. Complications During Pregnancy: ☐ No ☐ Yes

Explain: _____

12. List any past auto collisions: ☐ No ☐ Yes **How Many:** _____ **Was any care received?**

8. Ultrasounds During Pregnancy: ☐ No ☐ Yes **How Many:** _____

13. List any past falls bumps bruises: _____ **Was any care received?**

14. List any past sport, recreational, or home
injuries: _____

15. Please describe any past conditions and treatment received:

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐
Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐