eimc
ENDOBIOGENIC INTEGRATIVE MEDICAL CENTER

Endobiogenic Pediatric Health History Questionnaire
Ages 8-18

Name: _____ Today's Date: _____

Address: _____

Date of birth: _____ Phone: _____ Email: _____

Height: _____ Weight: _____ Blood Pressure (if known): _____

Parents names: _____

Primary care physician(s) name, address, phone: _____

_____

In the space below, please explain your goal in obtaining an Endobiogenic evaluation, including answering the following questions:

1. What are the symptoms your child is having?
2. How have these problems been evaluated and addressed in classical medicine?
   a) What tests have been done?
   b) What diagnosis has been given?
   c) What treatments have been recommended or tried?

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1.

2. a)

b)

c)

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Past health history/developmental history:

Birth weight_____ Birth length_____

Full term? (if not, how early or late?)_____

Hair on head at birth? _____ If yes, what color?_____

Was the pregnancy stressful in any way? _____

How long was labor? _____ Type of delivery: _____

Any complications during or after delivery? _____

What medications were given during pregnancy or labor? _____

Apgar scores (if known): _____

Past and Developmental History (continued)

Breastfed?_____How long?_____

Basic temperament of your child: _____

Calm or stressful childhood? _____

Is your child's growth (height) fast, slow, or average? _____

Is your child's weight gain fast, slow, or average? _____

Childhood illnesses or trauma: _____

Sat up at age: _____ Crawled at age: _____
Walked at age: _____ Spoke single words at age: _____
Spoke in short sentences at age: _____

Current grade in school: _____ Average grades earned in school: _____

Any possible **psychological traumas** for your child?

Surgeries, transfusions, other hospitalizations and dates:

Past medications taken on a regular basis and **vaccinations** received:

Medications, herbs or supplements your child is currently taking:

Allergies to drugs (describe the allergic reaction)

Lifestyle, habits, and family

Household includes :_____

Current diet: _____

Sports or activities? _____

Interests/Hobbies?_____

Pets? _____

How is relationship with father? _____
How is relationship with mother? _____
How is relationship with any siblings? _____

Family History: What is your child's ethnic heritage?_____

Any history in blood relatives of:

	Cancer		Dementia		Heart disease
	Diabetes		Depression		Hypertension
	Arthritis		Stroke or Seizures		Other

Review of systems:

Does your child sleep well at night? _____ How many hours on average?_____

Does he/she remember dreams? _____ Are they in color? _____

Does he/she hear sounds or conversations in your dreams? _____ Does he/she have unusual dreams or nightmares? _____Does he/she tend to take a nap during the day?_____

Are his/her hands and feet generally cold or hot? _____ Wet or dry? _____

Is his/her appetite generally increased, decreased, or average? _____

Does he/she tend to eat larger, smaller, or average quantities? _____

Does he/she tend to drink more, less, or average amounts of fluids?_____

Which does he/she prefer more: salt or sugar? _____

Is he/she hungry upon awakening in AM? _____

Does he/she seem to make much saliva? _____

Does he/she tend to sweat easily on the forehead or elsewhere? _____

Does your child seem to have any of the following? (In the blank, place a **C** for current problems and an **F** for frequent past problems)

	fatigue				muscle pain		urinary problems
	frequent headaches		cough		joint pain		weight gain or loss
	neck pain		difficulty breathing		back pain		frequent infections
	teeth grinding		abdominal pain		skin color changes		hyperactivity
	enlarged tonsils/glands		appetite disturbance		dry skin		easily startled
	nasal congestion		nausea		eczema or rashes		easily brought to tears
	sore throat		vomiting		acne or boils		anxiety
	environmental allergies		excess belching or gas		hair loss		depression
	chest pain		diarrhea		brittle nails		
	heart palpitations		constipation		new moles		

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____

(Young Women only)

Date of last menstrual period_____

Age of first menses_____

Days between menses (from first day to first day) _____

Length of menses_____

Any clotting or heavy bleeding?_____

Any cramping? _____

PMS symptoms if any_____

If breast pain/tenderness, where in breasts, and how many days? _____

Do you often have an abnormal vaginal discharge?_____

Do you have acne? (none) (mild) (moderate) (severe)

Do you have problems with excess hair growth on your face or body? _____

Have you removed any hair through shaving, plucking, waxing, or electrolysis? _____

How often do you shave your legs in the summer? _____