

Date:

Health History Questionnaire - Children

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Patient Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Mother's Name		Daytime phone	
		Evening phone	
Father's Name		Daytime phone	
		Evening phone	
Email Address			
Street address	Apt	City	Postal Code
Referred by		Date of last physical exam	

PERSONAL HEALTH HISTORY

Childhood illness	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
Immunizations and dates	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia				
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox				
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>				
	<input type="checkbox"/> DPT	<input type="checkbox"/> Hib				

Briefly describe bad effects from vaccination (if any)

Major complaints in order of importance

Complaint	Since	Causes
1.		
2.		
3.		
4.		

Surgeries or Major Injuries

Year	Reason for Surgery or Type of Injury	Complications?

Are there any circumstances or conditions (illnesses) from which your child has never been totally well?

Year	Condition

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Are they currently under the care of a Physician?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician	Treated for	Date	
Have they had homeopathic treatment before?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician	Treated for	Date	

Check each of the following conditions they have had			
<input type="checkbox"/> Abscesses	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Colitis	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Goiter
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Influenza
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Malaria	<input type="checkbox"/> Parasites
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Skin disease	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Warts	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Worms

List their prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the drug	Strength	Any adverse symptoms

Allergies to medications	
Name the drug	Reaction they had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	<input type="checkbox"/> Sedentary (No exercise)
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Please turn to next page

FAMILY HEALTH HISTORY

	AGE/AGE DECEASED	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
Paternal Aunts	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
Paternal Uncles	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
Maternal Aunts	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		
Maternal Uncles	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Paternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Paternal</i>		

Check any of the following conditions present in your family

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Gout
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Insanity	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Skin disease	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other (please describe)			

PREGNANCY AND DEVELOPMENT

Mother's age at childbirth:			
Select if any of the following were experienced during pregnancy			
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Nausea	<input type="checkbox"/> Illness	<input type="checkbox"/> Physical / Emotional trauma
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Medications	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs	<input type="checkbox"/> Cigarette consumption	<input type="checkbox"/> Miscarriage(s)	<input type="checkbox"/> Other
Birth History			
Birth Weight	Full Term	Premature	Late
Length of Labour	Complications		
List the age your child began the following activities:			
Sitting	Crawling	Walking	Talking
Feeding			
Breast fed <input type="checkbox"/> Yes <input type="checkbox"/> No	Duration	Formula	<input type="checkbox"/> Milk <input type="checkbox"/> Soy <input type="checkbox"/> Alternative
Are there any food intolerances?		Age they began solid food	
<i>Please turn to next page</i>			

MEDICAL/PROFESSIONAL WAIVER: PLEASE READ THE FOLLOWING CAREFULLY (under 19yrs of age require a parent or legal guardian's signature).

I the undersigned, understand that **Nicholas Mazzoli is a classically trained Homeopath and not a licensed medical doctor**. As such, I acknowledge that it is my responsibility to seek medical diagnosis and advice for my present and future conditions. In consulting with Nicholas Mazzoli, I am exercising my right to choose an alternative method of treatment through which to address my total health. As homeopathy is not covered by the existing government medical insurance plan, I agree to pay all fees presented in the current fee schedule. I also acknowledge that cancellation of appointments with less than 24hrs notice may result in a charge of \$100.00.

Patient's name

Signature (parent/guardian)

Witness

Date