



Marcus Porrino, ND
 Rebecca H. Porrino, ND
 710 West Napa Street
 Sonoma, CA 94576
 707-996-9355

Pediatric Patient Health History
 Birth to Five Years of Age

Name: _____
Last First M.I.

Date of Birth: _____ Age: _____ Gender:(circle one) F M

S.S.#: _____

Name and address of Dr's office/hospital/clinic where your child's health records are kept:

Office/Hospital/Clinic Name Street/ P.O. Box

City State Zip Code

Parent or Guardian: _____
Father Mother Guardian

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Please *circle the preferred number* to contact you:

Home #: _____ Work #: _____ Cell #: _____

E-mail: _____ S.S.#: _____

How did you find out about our clinic? _____

ALL RESPONSES WILL BE KEPT CONFIDENTIAL

What are your child's most important health problems?

- 1) _____ 3) _____
 2) _____ 4) _____

MEDICATIONS

Now = medications currently being taken. Past =medications taken at one time or another

	Now	Past		Now	Past
<i>Aspirin</i>	_____	_____	<i>Asthma Medications</i>	_____	_____
<i>Ibuprofen</i>	_____	_____	<i>Decongestants</i>	_____	_____
<i>Inhalers</i>	_____	_____	<i>Topical Steroids</i>	_____	_____
<i>Antibiotics</i>	_____	_____	<i>Other</i>	_____	_____
<i>Anti-histamine</i>	_____	_____		_____	_____



Marcus Porrino, ND
Rebecca H. Porrino, ND
710 West Napa Street
Sonoma, CA 94576
707-996-9355

MEDICAL HISTORY

Does your child have any **allergies** to foods, drugs or other allergens in your environment (cats, mold, dust)? Yes _____ No _____ If yes, list and explain. _____

Has your child ever had: (Check those that are applicable)

_____ *Chicken pox* _____ *Scarlet fever* _____ *Bronchitis* _____ *Asthma*
_____ *Measles* _____ *Pneumonia* _____ *Rubella* _____ *Mumps*
_____ *Frequent Colds* _____ *Eczema* _____ *Croup*
_____ *Tonsillitis-How many times?* _____ *Ear infections-How many?* _____ *Other* _____

X-RAYS AND SPECIAL STUDIES

	When	Where	Results
<i>Electroencephalogram:</i>	_____	_____	_____
_____ <i>Psychological Evaluation:</i>	_____	_____	_____
_____ <i>Hearing:</i>	_____	_____	_____
_____ <i>Speech/Language:</i>	_____	_____	_____

INJURIES/SURGERIES/HOSPITALIZATIONS

IMMUNIZATIONS

_____ *Measles* _____ *Polio* _____ *MMR* _____ *Small Pox* _____ *Hep B*
_____ *Mumps* _____ *DPT* _____ *Tetanus* _____ *Influenza* _____ *Other* _____

Any adverse reactions to immunizations? (Please specify)

As a baby, did/does your child have any of the following problems?

_____ *Jaundice* _____ *Diarrhea* _____ *Birth defects* _____ *Rashes*
_____ *Colic* _____ *Fever* _____ *Cerebral palsy* _____ *Allergies*
_____ *Blue baby* _____ *Seizures* _____ *Birth injuries* _____ *Other* _____

Feeding: _____ *Breast fed* _____ *How long?* _____ *Formula: Milk or Soy*

Age Began: _____ *Solid foods* _____ *Sitting* _____ *Crawling*
_____ *Walking* _____ *First words*

What were your child's sleep patterns the first year? _____



Marcus Porrino, ND
 Rebecca H. Porrino, ND
 710 West Napa Street
 Sonoma, CA 94576
 707-996-9355

SYMPTOMS

Please circle: Y=a condition your child has now N=never had P=has had in the past

<i>Hives</i>	Y P N	<i>Burning of urine</i>	Y P N	<i>Bloody urine</i>	Y P N
<i>Eczema</i>	Y P N	<i>Frequent urination</i>	Y P N	<i>Cries easily</i>	Y P N
<i>Bleeding gums</i>	Y P N	<i>Heart Murmur</i>	Y P N	<i>Nervous</i>	Y P N
<i>Nose bleeds</i>	Y P N	<i>Vomiting spells</i>	Y P N	<i>Sleep problems</i>	Y P N
<i>Acne</i>	Y P N	<i>Anemia</i>	Y P N	<i>Night sweats</i>	Y P N
<i>High fever</i>	Y P N	<i>Stomach aches</i>	Y P N	<i>Sensitive to light</i>	Y P N
<i>Chronic rash</i>	Y P N	<i>Jaundice</i>	Y P N	<i>Body/Breath odor</i>	Y P N
<i>Hearing loss</i>	Y P N	<i>Easy bruising</i>	Y P N	<i>motion/car sick</i>	Y P N
<i>Diarrhea</i>	Y P N	<i>Flat feet</i>	Y P N	<i>No appetite</i>	Y P N
<i>Sore throats</i>	Y P N	<i>Constipation</i>	Y P N	<i>Nightmares</i>	Y P N
<i>Gas</i>	Y P N	<i>Canker sores</i>	Y P N	<i>Wheezing</i>	Y P N
<i>Joint pains</i>	Y P N	<i>Cough</i>	Y P N	<i>Dizzy spells</i>	Y P N
<i>Hair loss</i>	Y P N	<i>Frequent Headaches</i>	Y P N	<i>Frequent colds</i>	Y P N
<i>Unusual fears</i>	Y P N	<i>Bleeding tendency</i>	Y P N	<i>Excessive fatigue</i>	Y P N

Does your child have any other condition not mentioned? _____

DIET

Please briefly describe your child's typical daily diet: _____

Does your child have any food intolerance's that you know of? Yes _____ No _____
If yes, please explain: _____

FAMILY HISTORY

Heart Disease *Diabetes* *Birth defects* *Cancer* *Mental Illness*
 Hypertension *Arthritis* *Tuberculosis* *Allergies* *Hay fever*
 Eczema *Other (please explain)* _____

BIRTH HISTORY

Previous Pregnancies by natural mother, miscarriages or complications: _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

Bleeding *Hypertension* *Illness* *Cigarettes, alcohol, drugs*
 Nausea *Diabetes* *Thyroid Problems*
 Physical or emotional trauma



Marcus Porrino, ND
Rebecca H. Porrino, ND
710 West Napa Street
Sonoma, CA 94576
707-996-9355

Delivery/Term:

___ *Full* ___ *Premature* ___ *Late*
___ *Length of labor* *Complications?* ___ *Yes* ___ *No*

_____ *Weight at Birth* _____ *Length* _____ *Head*

Are there any cultural or religious practices we should be aware of when providing healthcare to you?

Is there any information about your health you would like to add:

Please fax or mail this intake form or bring it on your first visit::

Sonoma Naturopathic Medicine
710 West Napa Ave
Sonoma, CA 95467
FAX(707) 996-9356