

Integrative Family Medicine, LLC

10440 Shaker Drive, Suite 103
Columbia, MD 21046
O/F 888-953-0005

Provider: Jennifer Rabenhorst, MD Date: ____ - ____ - ____

Patient: _____

DOB: ____ - ____ - ____ Age: ____ Grade: ____

Child History Form

Please list **SPECIAL PROBLEMS** you would like evaluated today in order of significance:

- 1.
- 2.
- 3.

MEDICATION ALLERGIES: (such as penicillin)
What happens when you take that medicine?

OTHER ALLERGIES: (such as bees/wasps, foods, latex, etc)
What happens when you are exposed:

MEDICATIONS: Prescription and Non-Prescription (including aspirin, vitamins, birth control, herbs, supplements, etc.)

BIRTH HISTORY

Include Mom's health during pregnancy, Full-term/Pre-term, Abnormal Labor, Vaginal Del/Cesarean (why?), etc

PAST MEDICAL HISTORY

Please describe and give dates of any illnesses, injuries, hospitalizations, and surgeries

History of Head Trauma?

Date of Last Physical?

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IMMUNIZATIONS Up to Date?

If No, explain (I.e. behind on Hep B, Religious objection, etc)

Adverse reactions noted?

FAMILY HISTORY

(Any History of Cancer, food allergies, Celiac Disease, Irritable Bowel, Psychiatric, Alcohol/Drug Abuse, Thyroid or other Hormonal Disease, etc)

Siblings?

Maternal Side *(Include when Mother went through Menopause if applicable)*

Paternal Side

SOCIAL HISTORY

Dietary Restrictions:

Daily Beverage Consumption (Amount and Type)

Eat Out How Often (per day, week, month)?

Typical Diet (Each meal and snacks)

Exercise (Type, Duration, Frequency)

Smoke (pack per day/week)?

Alcohol (amount, frequency)?

Other Drugs?

Describe Home Dwelling (Age, how long resided, wet basement, concerns for lead, etc)

School Problems (Past/Current)

Be sure to attach any other pertinent information, and have a copy of the medical records and most recent labs forwarded to my office (Fax 410-888-9004).

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Patient: _____

DOB: - - - - - Age: Grade:

REVIEW OF SYSTEMS: Check the **Yes** or **No** column for those symptoms you currently have significant problems with.

Yes	No	General	Yes	No	Gastroenterology	Yes	No	Dermatology
		Fever			Nausea			Rash
		Chills			Vomiting			Itching
		Sweats			Diarrhea			Dryness
		Poor appetite			Constipation			Suspicious skin lesions
		Fatigue			Change in bowel habits			
		Weakness			Abdominal pain	Yes	No	Neurology
		Just don't feel well			Black or tar-like stools			Paralysis
		Weight loss			Bloody stools			Unusual sensations
		Sleep problems			Jaundice (skin turned yellow)			Seizures
					Gas/Bloating			Tremors
Yes	No	Eyes			Indigestion/Heartburn			Vertigo / Dizziness
		Blurring of your vision			Difficulty swallowing			Temporary blindness
		Double vision			Pain with swallowing			Frequent falls
		Irritation of the eyes						Frequent headaches
		Discharge of the eyes	Yes	No	Genitourinary			Difficulty walking
		Vision loss or change			Vaginal discharge			
		Eye pain			Incontinence / Leaking urine	Yes	No	Psychiatric
		Eyes are sensitive to light			Painful urination			Depression
					Blood in the urine			Anxiety
Yes	No	Ears, Nose, Throat			Frequent urination			Memory loss
		Earache			Missed periods			Suicide thoughts
		Ear discharge			Heavy periods			Hallucinations
		Tinnitus / Ringing in Ears			Unusual vaginal bleeding			Paranoia
		Decreased hearing			Pelvic pain			Phobia / Fear of things
		Nasal congestion			Genital sores			Confusion
		Nose bleeds						
		Hoarseness				Yes	No	Endocrinology
			Yes	No	Musculoskeletal			Cold intolerance
Yes	No	Cardiovascular			Back pain			Heat intolerance
		Chest pains			Joint pain			Constantly thirsty
		Palpitations / Skipped beats			Joint swelling			Constantly hungry
		Syncope / Fainting			Muscle cramps			Constantly need to urinate
		Difficult breathing on exertion			Muscle weakness			Unusual weight change
		Difficult breathing laying down			Stiffness			
		Shortness of Breath at night			Arthritis	Yes	No	Hemetology
		Swelling in your legs or ankles			Sciatica / Pain down the legs			Unusual bruising
					Restless legs			Unusual bleeding
Yes	No	Respiratory			Leg pain at night			Enlarged lymph nodes
		Cough			Leg pain with exertion			
		Difficult breathing at rest				Yes	No	Allergy
		Excessive sputum / phlegm						Hives
		Coughing up blood						Allergic rash
		Wheezing						Hayfever
		Chest pain with deep breathing						Recurrent infections