CHILD HEALTH HISTORY

To help us meet your healthcare needs, please fill out this form completely in ink. This is a confidential record of your child's health history.

Today's date: ______________________
Child's name: (Last, First, M.I.): ______________________________ Date of birth: ________ Age: ______
Ethnicity (optional): ____________________________________ Gender (optional): ________________
Parents' names (Last, First M.I.): __________________________________ Phone: ___________________
__________________________________ Phone: ___________________
What is your goal for your child's visit? (If well child exam, please state): _____________________________
____
Are there any specific conditions that you are concerned about? _______________________________________
____
What have you, the parent, already done to help your child be healthier? _______________________________
____
Name of primary care doctor: ____
Serious illness, trauma, surgery or hospitalization that your child has experienced: ______________________
____
Food allergies/ intolerances and reactions they cause: ____
____
Drug allergies/ reactions: ____
____
Environmental allergies: ____

FAMILY BACKGROUND:
Who does your child live with? ____
Are parents divorced? _____ If so, what type of arrangements (visitation, etc.) are made for the other parent?
____

FAMILY MEDICAL HISTORY:
Please mark relationship of anyone in your family that has had the following conditions: (M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, MM or FM = mother or father's mother, MF or FF = mother or father's father, MGM or FGM = mother or father's grandmother, MGF or FGF = mother or father's grandfather).

High blood pressure	_____	Heart disease	_____	Stroke	_____
Bleeding tendency	_____	Epilepsy	_____	Allergies	_____
Drug/alcohol problem	_____	Cancer	_____	Asthma	_____
Mental Illness	_____	Ulcer	_____	Obesity	_____
Migraine headaches	_____	Gout	_____	Depression	_____
Thyroid disease	_____	Kidney disease	_____	Other:_____________	
High cholesterol	_____	Diabetes	_____		

BIRTH HISTORY:
1. Did mother receive prenatal care?_________Take prenatal vitamins?______________________________
2. State of mother's health during pregnancy____
3. Did mother smoke cigarettes?__________Drink alcohol?___________Take drugs?___________________

4. What type of birth? ________________________________How long was labor?___________________
5. Carried to term? _________________________________If no, how premature?__________________
6. Birth weight? ________ Birth length? ________ Apgar scores________________________________
7. Any complications of labor or delivery?____

HEALTH HISTORY: How often does your child experience:

Colds/runny nose	______	Sore throats	______	Diarrhea	______	Earaches	______
Coughs	______	Constipation	______	Headaches	______	Tummy aches	______
Diaper rash	______	Other rashes	______	Eczema	______	Trouble sleeping	______

Others____

Has your child been immunized? Update: DTaP_____Polio_____HIB_____Hep B_____MMR_____
PCV_____Chickenpox_____Rota_____

What medications has your child been on? (Include details: How often, how long) ____________________
____

ENVIRONMENTAL HISTORY:
Do you have indoor pets?__________If so, what kind?____
What type of dwelling do you live in?__________________________How old?_______________________
Any remodeling recently?______Has your child been exposed to any chemicals or toxins?________________
Do you heat with a wood stove?______Does anyone in the family smoke cigarettes?_____________________

DIET:
1. What does your child typically eat?
   Breakfast:____
   Snack:____
   Lunch:____
   Snack:____
   Dinner:____
   Snack:____
   What does she/he drink and how much?____

2. What foods does your child enjoy?____
   Dislike?____

3. What supplements does your child take and how often?____
   ____

STRESSES:
Has your child experienced many stresses in his/her lifetime?_____What kind?_________________________
____

SLEEP:
How much sleep does your child get?________________From:_______ p.m. to _______ a.m.

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary health care services my child may need.

____ ________________________
Signature of patient's parent Date