Health History Form

CHILD'S NAME:_____ DATE OF BIRTH:_____AGE_____

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER_____

PRESENT HEALTH CONCERNS_____

HOW DID YOU HEAR ABOUT US?_____

MEDICINES/VITAMINS_____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS:_____

PREGNANCY & BIRTH

Where was your child born?_____

Is the child yours by: Birth Adoption Stepchild Other:_____

Please indicate any medical problems during pregnancy None Specify:

_____

Delivery by Vaginal birth Caesarean If Caesarean, why?_____

Birth weight:_____ Birth length:_____

Please indicate any medical problems during the baby's newborn period:

None_____ If premature, How early?_____Other problems:_____

NUTRITION & FEEDING

Was/is your child breastfed? NO YES If so, how long?_____

Has your child had any feeding/dietary problems? NO YES If yes, specify:

_____

_____

Milk intake now: Type: Cow's milk (Nonfat 1% fat 2% fat Whole milk) Soy Milk Rice Milk

Average ounces per day (Note 8 ounces = 1 cup)_____

SLEEP

Hours per night_____Naps (number & length)_____

Any sleep problems?_____

DEVELOPMENT (Do not fill out this section if filling out ASQ questionnaire)

At what age did your child:

Sit Alone_____ Walk Alone_____ Say Words_____ Toilet Train (daytime)_____

Girls only: Age at first menstrual period_____

DENTAL HISTORY:

Has your child been seen by a dentist? No Yes

If so, how often?_____ Date of last visit_____

Water Source: City or Well_____

SCHOOL HISTORY:

Did/does your child attend school or preschool? No Yes

Current grade_____ Name of school_____

Any concerns about school performance?_____

Any concerns about relationship with: Teachers No Yes

Students No Yes

REVIEW OF SYMPTOMS: Please circle any current problems your child has on the list below:

Constitutional

Fever/chills/excessive sweating

Unexplained weight loss/gain

Eyes

Squinting/crossed eyes

Ears/Nose/Throat

Unusually load voice/hard of hearing

Mouth breathing/snoring

Bad Breath

Frequent runny nose

Problems with teeth/gums

Cardiovascular

Tires easily with exercise

Shortness of breath

Fainting

Respiratory

Cough/Wheeze

Chest Pain

Gastrointestinal

Nausea/vomiting/diarrhea

Constipation

Blood in Bowel Movement

Genitourinary

Bedwetting

Pain with urination

Discharge: penis or vagina

Musculoskeletal

Muscle/joint pain

Skin

Rashes

Unusual moles

Allergy

Hay Fever/itchy eyes

Neurological

Headaches

Weakness

Clumsiness

Psychiatric/Emotional

Speech problems

Anxiety/stress

Problem with sleep/nightmares

Depression

Nail biting/thumb sucking

Bad temper/jealousy

Blood/Lymph

Unexplained lumps

Easy bruising/bleeding

SAFETY:

When your child is in the car, does he/she use: An infant seat_____ A booster seat_____ Seatbelt_____

Do you have smoke detectors in your home? Yes or No

Does your child wear a helmet for a Bike/Scooter or ATV? Yes or No

IMMUNIZATIONS:

Up to date: Yes or No Date of last set of immunizations_____

Has your child had: Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)

Do any household members smoke? Yes or No

TV-hours per day_____ Computer hours per day_____ Video games hours per day_____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates.

_____

_____

_____

Hospitalizations/operations (with dates)_____

_____

Broken bones or severe sprains:_____

FAMILY HISTORY: Please check below if any immediate (parent, sibling, or grandparent) family members have any of the listed conditions:

Alcoholism_____ Stroke _____

High Cholesterol_____ Depression/Suicide _____

Cancer, please specify type_____ Diabetes_____

High Blood Pressure_____ Other_____

Heart Attack_____ Other_____

SOCIAL HISTORY:

Who lives at home?

Name Age Relationship

_____

_____

_____

_____

_____

Are your child's parents: Married Unmarried Separated Divorced

Child care: Parents Daycare Other_____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Any violence at the home? Yes or No

Are there guns in the home? Yes or No