

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

DOB \_\_\_\_\_  M  F

CHILD HEALTH HISTORY

INSTRUCTIONS: Put an (X) in the appropriate box for each question. DO NOT SKIP ANY.

CHILD'S BIRTH WEIGHT: \_\_\_\_\_  
CHILD'S GRADE IN SCHOOL (IF APPLICABLE): \_\_\_\_\_  
WHAT IS YOUR JOB? \_\_\_\_\_

CHECK THE APPROPRIATE BOX FOR CHILD'S PARENTS:

- Never married  Living with partner  Married now  
 Separated  Divorced  Widowed

CHECK THE APPROPRIATE BOX:

- American Indian or Alaskan Native  Asian or Pacific Islander  
 Black, not of Hispanic origin  Hispanic  
 White, not of Hispanic origin  Other

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HISTORY:

Yes No

- Were there any complications during the pregnancy?
- Were there any complications during the birth and delivery?
- Was the pregnancy full-term (9 months or 40 weeks?)
- Were there any problems with the child immediately after birth?
- Did the child go home with mother?
- Did the child have any problems with jaundice?
- Does the child have any birth defects?
- Does the child have any problems with feeding or nutrition?
- Are the child's immunizations up to date?  
(Please have the child's immunization records available.)
- Does anyone in the child's home smoke?
- Is your child exposed to sources of lead that you know about?

LIST ANY INJURIES OR FRACTURES (ALSO LIST AGE):

\_\_\_\_\_  
\_\_\_\_\_

LIST ANY OPERATIONS (ALSO LIST AGE):

\_\_\_\_\_  
\_\_\_\_\_

LIST ANY HOSPITALIZATIONS (ALSO LIST AGE):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAS YOUR CHILD EVER HAD:

Yes No

- Anemia (low blood count)
- Arthritis
- Asthma
- Bronchitis or pneumonia
- Cancer
- Dental problems
- Diabetes mellitus
- Ear infections
- Epilepsy/seizure disorder
- German measles
- Hayfever or seasonal allergies
- Hearing problems
- Heart disease
- Learning or attention difficulties
- Measles
- Mental or emotional problems
- Mumps
- Polyps or growth in bowels
- Rheumatic fever
- Tonsillitis or step throat
- Vision problems (NOT glasses)
- Weight problem
- Other (please list below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CONTINUE ON BACK

LIST NON-PRESCRIPTION DRUGS YOUR CHILD REGULARLY TAKES:	LIST ANY PRESCRIPTION DRUGS THAT YOUR CHILD TAKES:	LIST ANY DRUGS THAT YOUR CHILD IS ALLERGIC TO:

HAVE ANY OF YOUR CHILD'S BLOOD RELATIVES EVER HAD:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drinking or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	Obesity
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Birth defect	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Suicide or attempted suicide
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list below)
<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Mental or emotional problems	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Nerve or muscle disease	_____		

DO YOU OR YOUR FAMILY HAVE ANY CONCERNS OR PROBLEMS WITH:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Other family members	<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Recent death of spouse, friend, or family member
<input type="checkbox"/>	<input type="checkbox"/>	Friends	<input type="checkbox"/>	<input type="checkbox"/>	Recent loss of job or retirement	<input type="checkbox"/>	<input type="checkbox"/>	Neighborhood violence
<input type="checkbox"/>	<input type="checkbox"/>	Housing or living arrangements	<input type="checkbox"/>	<input type="checkbox"/>	Mental or emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Family violence
<input type="checkbox"/>	<input type="checkbox"/>	Finances	<input type="checkbox"/>	<input type="checkbox"/>	Serious illness or disability	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list below)
<input type="checkbox"/>	<input type="checkbox"/>	Education	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug use	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Job or employment	<input type="checkbox"/>	<input type="checkbox"/>	Recent break-up, separation, or divorce	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Legal						

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS (WHERE POSSIBLE):

Name(s)	Gender	Date of Birth/Age	Marital Status	Living at home?
Parents:				
Children:				
Others living in household:				

PLEASE LIST ANY ADDITIONAL PROBLEMS, CONCERNS, OR INFORMATION ABOUT YOU OR YOUR FAMILY THAT YOU WOULD LIKE THE HEALTH CARE PROVIDER TO KNOW ABOUT:

---



---

SIGNATURE (PARENT) \_\_\_\_\_