HEALTH HISTORY

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PATIENT NAME_____ BIRTH DATE_____ SEX_____

Mother's Name_____ Age_____ Father's Name_____ Age_____

Occupation _____ Occupation_____

If adults in the household work outside the home, what childcare arrangements are made for this child?_____

_____

A. Pregnancy and birth: (circle "no" or "yes"' leave blank if uncertain)

1. Did the mother have any illness during pregnancy? ..... no yes
2. Were any other medications other than vitamins and iron taken during pregnancy? ..... no yes
3. Was the baby born on the calculated due date? ..... yes no
4. What was the birth weight? ..... _____
5. Did the baby have any trouble starting to breathe? ..... no yes
6. Did the baby have any trouble while in the hospital? (jaundice, infection, other?) ..... no yes

B. **Past Medical History:** (circle "no" or "yes"' leave blank if uncertain)

1. Where has your child gone for check-ups until now? ..... _____
2. Date of last check-up ..... _____
3. Date of last dental check-up (if applicable) ..... _____
4. Has your child had allergic reactions to any medications, food, insect bites, or immunizations? ..... no yes
5. Any hospitalizations other than for birth? ..... no yes
6. Any serious injuries? ..... no yes
   If "yes", please give details_____
7. Are any medications taken regularly? ..... no yes
   If "yes", please list_____

C. Family History:

1. Are the child's parents both in good health? yes no
2. Circle any diseases that this child's parents, grandparents, brothers, sisters or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, cancer, AIDS, or learning disabilities.
3. List age, sex and general health of brothers and sisters_____
   _____
4. Have any of your children died? no yes

D. Feeding and Nutrition

1. Is your child's appetite usually good? yes no
2. Is it good now? yes no
3. Was there severe colic or any unusual feeding problem during the first three months? no yes
4. Do any foods seem to disagree with him/her? no yes
5. For the first 6 months, was he/she (is he/she) breast or bottle fed?_____
6. If still on formula, which one do you use?_____
7. Does he/she take vitamins or fluoride? _____

A. Review of Systems:

1. Has your child had frequent ear infections?	no	yes
2. Any eye problems?	no	yes
3. Has he/she had any problems with teeth?	no	yes
4. Does he/she have frequent colds or sore throats?	no	yes
5. Is there a history of asthma, pneumonia or recurrent cough?	no	yes
6. Does he/she have a heart murmur or any heart problem?	no	yes
7. Any problems with urination, diarrhea or constipation?	no	yes
8. Have there been any convulsions or other problems with the nervous system?	no	yes
9. Any eczema, hives or other skin conditions?	no	yes
10. Has your child ever been anemic?	no	yes

11. Please list any other medical problems_____

_____

F. Development/Behavior:

1. At what age did your child sit alone?	_____	
2. At what age did he/she walk alone?	_____	
3. Did he/she say any words by the time he/she was 18 months old?	yes	no
4. Does he/she have any trouble sleeping?	no	yes
5. What grade is he/she in?	_____	
6. Has he/she had any trouble in school?	no	yes
7. Does he/she get along well with other children?	yes	no
8. Circle if your child has had any of the following: bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others		

G. Safety/Environment:

1. Is your water heater set at 120 degrees Fahrenheit?	yes	no
2. Is there a working smoke alarm on each floor of your house?	yes	no
3. Does your child always use a car seat or seat belt in the car?	yes	no
4. Are there any smokers in your home?	no	yes
5. Are there any guns in your home?	no	yes
6. Does your child always wear a bike helmet when riding his/her bike?	yes	no