Health Check History Form

HEALTH CHECK
HISTORY FORM

Member Name _____

Member ID _____

Date _____ Age____

☐ Medicaid ☐ PeachCare

Information obtained from:

☐ Member ☐ Guardian ☐ Both

General Information

☐ Female ☐ Male DOB: _____

Allergies

_____

_____

_____

Current Medications

Name	Dosage	Last taken
1		
2		
3		
4		

Current Medical History

_____

_____

_____

_____

_____

Maternal/Birth History

☐ Full Term ☐ Premature _____ (wks)

Birth Weight _____

Delivery: ☐ Vaginal ☐ C-Section

Duration of Labor _____

Problems with pregnancy: ☐ Rubella ☐ Toxemia

☐ UTI ☐ Excessive Weight Gain

☐ Alcohol/Drugs ☐ Other _____

Newborn History

Breast feed Formula

Feeding problems Slow wt. Gain

Colic Jaundice

Blood in stool Recurrent vomiting/diarrhea

Other

Values

Religion _____ Culture _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes ☐ No	When _____
Frequent ear infection	☐ Yes ☐ No	Explain _____
Problems with hearing	☐ Yes ☐ No	Explain _____
Nasal Allergies	☐ Yes ☐ No	Explain _____
Problems with vision	☐ Yes ☐ No	Explain _____
Asthma, bronchitis, etc.	☐ Yes ☐ No	Explain _____
Heart Problem	☐ Yes ☐ No	Explain _____
Bleeding Problem	☐ Yes ☐ No	Explain _____
Blood Transfusion	☐ Yes ☐ No	Explain _____
Stomach Pain	☐ Yes ☐ No	Explain _____

Skin Problems	☐ Yes ☐ No	Explain	_____
Headaches	☐ Yes ☐ No	Explain	_____
Neurologic problems	☐ Yes ☐ No	Explain	_____
Diabetes	☐ Yes ☐ No	Explain	_____
Injuries	☐ Yes ☐ No	Explain	_____
Use of Alcohol/Drugs	☐ Yes ☐ No	Explain	_____
Any other problem	☐ Yes ☐ No	Explain	_____

Household

People living in the child's home:

Name	Relationship to child	Birth date	Health Problems

Family History

Deafness	☐ Yes ☐ No	Who _____
Nasal Allergies	☐ Yes ☐ No	Who _____
Asthma	☐ Yes ☐ No	Who _____
Immune Problems	☐ Yes ☐ No	Who _____
Mental Retardation	☐ Yes ☐ No	Who _____
Mental Illness	☐ Yes ☐ No	Who _____
Tuberculosis	☐ Yes ☐ No	Who _____
Drug Abuse	☐ Yes ☐ No	Who _____
Alcohol Abuse	☐ Yes ☐ No	Who _____
Heart Disease	☐ Yes ☐ No	Who _____
High Blood Pressure	☐ Yes ☐ No	Who _____
High cholesterol	☐ Yes ☐ No	Who _____
Epilepsy	☐ Yes ☐ No	Who _____
Anemia	☐ Yes ☐ No	Who _____
Bleeding Disorder	☐ Yes ☐ No	Who _____
Liver Disease	☐ Yes ☐ No	Who _____
Kidney Disease	☐ Yes ☐ No	Who _____
Diabetes	☐ Yes ☐ No	Who _____
Any other problem	☐ Yes ☐ No	Who _____

Social History

Day Care	☐ Yes ☐ No	
School Grade	☐ Yes ☐ No	_____

Smoking in Home ☐ Yes ☐ No

Additional Comments

History Reviewed By/Date_____ Signature_____