CHILD HEALTH HISTORY

Child's Name:_____ M____F____ Today's Date:_____

Mother's Name:_____ Occupation:_____ DOB:_____

Father's Name:_____ Occupation:_____ DOB:_____

BIRTH HISTORY

Child's Birth Date:_____ Child's Birth Weight:_____ Length of Pregnancy:_____

During pregnancy, were there any of the following problems?

☐ German Measles ☐ High Blood Pressure ☐ Surgery
☐ Injury/Accident ☐ Infection ☐ Bleeding

Were any medications or drugs taken during pregnancy (please include alcohol, cigarettes, prescription drugs, and other street drugs)?_____ If yes, what?_____

_____

At birth and immediately after, did baby have:

☐ Delayed Breathing ☐ Administered Oxygen ☐ Infection
☐ Blood Transfusion ☐ Incubator ☐ Jaundice
☐ Other:_____

GROWTH AND DEVELOPMENT

At what age did this child:

Sit alone_____
Walk_____
Talk (2 word sentences)_____
Become toilet trained during the day_____
Become toilet trained at night_____

Is your child allergic to any medications?_____ Which ones?_____

Is your child currently taking any medications?_____ What?_____

Has this child had any allergic reactions to medications or foods?_____ (If yes, please describe)

Has your child ever had:	Yes	No		Yes	No
Asthma / Shortness of breath			Heart Murmur		
Hay Fever			Bed-wetting		
Eczema/Hives			Urinary tract infections		
Ear Infection			Bladder Infection		
Hearing Problems			Tonsillitis		
Vision problems			Surgery or Hospitalization		
Frequent Constipation			Broken Bones		
Frequent Diarrhea			Treatment for Poisoning		
Pneumonia			Injury resulting in unconsciousness		
Joint pain or swelling			Inability to Sleep		
Convulsions			Excessive thirst		

PLEASE COMPLETE OTHER SIDE...

Does this child have any of the following problems?

- ☐ Frequent temper tantrums
- ☐ Over-activity (can't sit still)
- ☐ Can't concentrate
- ☐ Disturbs others in class
- ☐ Picks fights
- ☐ Learning disabilities
- ☐ Overly timid or shy
- ☐ Other behavior problems:_____

FAMILY HISTORY

Names and ages of siblings:_____

Has a parent or child died?_____ If yes, what was the cause?_____

Are any of the children adopted?_____ If yes, at what age?_____

Child's primary care provider:_____

FAMILY MEDICAL HISTORY

Illness	Yes	No	Family Member	Illness	Yes	No	Family Member
Diabetes				Ulcerative colitis			
Tuberculosis				Stomach Ulcers			
Epilepsy/Convulsions				Kidney disease			
Bleeding disorder				Migraine headaches			
Anemia				Cancer			
Mental Illness/Retardation				Asthma			
Rheumatic fever				Hay fever			
Rheumatoid arthritis				Cystic fibrosis			
Heart disease				Lung disease			
Thyroid goiter				Tay Sachs disease			
Muscular dystrophy				Sickle cell disease			
Eye problems/glaucoma				Ear problems/deafness			
High blood pressure				Birth defects			
Immune Diseases				Other:			

Have there been any major changes in the family in the past year?_____

CHILD'S HEALTH

Has your child ever been hospitalized?_____ For what?_____

Has the child had any serious accidents?_____ What?_____

How does your child adapt to new situations?_____

What are your child's favorite activities?_____

Does your child clean his/her teeth?_____ Child's dentist:_____

Do you have any specific concerns about your child's health?_____

_____

For office use:

Reviewed	Date
By:_____	_____
By:_____	_____
By:_____	_____