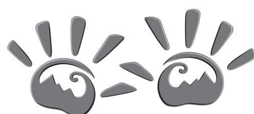

HEALTH HISTORY

NAME

SEX ☐ MALE ☐ FEMALE	RACE	SOCIAL SECURITY NUMBER	DATE OF BIRTH

Please list all people in the household:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father			
Mother			
Other			
Other			
Other			
Other			

Have there been any recent major changes or stresses in the child's life? ☐ YES ☐ NO

If YES, Explain ____

____

Does child go to a baby sitter, preschool or day care regularly? ☐ YES ☐ NO

BIRTH HISTORY:

Birth Weight ______________________ Length ______________________ Place ______________________

During the pregnancy did the mother see a doctor regularly? ☐ YES ☐ NO

During pregnancy did the mother: (If YES, Explain) Explanation

Have any medical problems? ☐ YES ☐ NO ______________________

Smoke or drink? ☐ YES ☐ NO ______________________

Use any medications? ☐ YES ☐ NO ______________________

Use alcohol or other drugs? ☐ YES ☐ NO ______________________

Have problems with labor/delivery? ☐ YES ☐ NO ______________________

How long did the baby stay in the hospital after birth? ______________________

PAST MEDICAL HISTORY:

Is the child's general health: ☐ GOOD ☐ FAIR ☐ POOR Explanation

Does the child have any allergies? ☐ YES ☐ NO ______________________

Is the child taking any medications? ☐ YES ☐ NO ______________________

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

____ Date: ______________

____ Date: ______________

Has the child ever had any problems with the following. If YES, please explain.

Eyes/Vision	☐ YES	☐ NO	________
Feet	☐ YES	☐ NO	________
Digestion/Nutrition	☐ YES	☐ NO	________
Ears/Hearing	☐ YES	☐ NO	________
Urine/Kidneys	☐ YES	☐ NO	________
Joints	☐ YES	☐ NO	________
Skin	☐ YES	☐ NO	________
Lungs	☐ YES	☐ NO	________
Teeth	☐ YES	☐ NO	________
Heart	☐ YES	☐ NO	________
Seizures	☐ YES	☐ NO	________
Repeated Infections	☐ YES	☐ NO	________

FAMILY HISTORY

Have any of the child's brothers or sisters died? ☐ YES ☐ NO ________

If YES, give age and cause ________

Have any of the child's blood relatives had the following diseases? If YES, please list family member.

Heart Disease	☐ YES	☐ NO	________
Tuberculosis	☐ YES	☐ NO	________
High Blood Pressure	☐ YES	☐ NO	________
Kidney Disease	☐ YES	☐ NO	________
Allergies/Asthma	☐ YES	☐ NO	________
Cancer	☐ YES	☐ NO	________
Diabetes	☐ YES	☐ NO	________
Mental/Emotional Problems	☐ YES	☐ NO	________
Sickle Cell	☐ YES	☐ NO	________
Seizures	☐ YES	☐ NO	________

DEVELOPMENT

Do you have any concerns about the following? If YES, please explain.

Development	☐ YES	☐ NO	________
Behavior	☐ YES	☐ NO	________
Eating Habits	☐ YES	☐ NO	________
Sleeping Habits	☐ YES	☐ NO	________
School Experience	☐ YES	☐ NO	________
Bathroom/Toilet Habits	☐ YES	☐ NO	________
Discipline	☐ YES	☐ NO	________
Other (explain)	☐ YES	☐ NO	________

IMMUNIZATIONS

Up to date? ☐ YES ☐ NO

Reviewed By: ________ Date: ________