Child history (0-14 years)

Name	DOB	Age	Gender	
Mother's name		Occupation:		DOB
Father's name		Occupation:		DOB

Brothers: (Name/DOB)

Sisters: (Name/DOB)

Child's Medical History

Has this child had any: (if yes, explain below)

Y/N Serious accidents, head trauma, broken bones
Y/N Hospitalizations
Y/N Surgies
Y/N Recurrent infections (ear, throat, lung infections)
Y/N Allergies, asthma
Y/N Chicken pox Date:
Y/N Bladder infection, kidney problems, undescended testicles
Y/N Seizures
Y/N Serious dental problems
Y/N Learning or developmental problems
Y/N Speech, hearing or vision problems
Y/N Emotional/behavioral problems
Y/N Has this child been hit, slapped, kicked or otherwise physically hurt by someone?

Does this child:

Y/N Wear glasses?
Y/N Take any medications?
Y/N Take any vitamins?
Y/N Take any fluoride?

Where has this child gone for prior medical care?

Date of last dental exam:
Date of last medical exam:

Use this space to explain any of the above YES answers:

Child's Medical History (female only)

Age at first period:
Last menstrual period:
Number of days between periods:
Y/N Cramps?
Y/N Bleeding between periods?
Y/N Has child ever had a pelvic or internal exam?

Family Medical History

Have these health problems occurred in the child's family? (include child's natural parents, brothers, sisters, grandparents)

Y/N Allergies, asthma, lung disease:
Y/N Tuberculosis
Y/N Blood problems:
Y/N Diabetes
Y/N Thyroid disease
Y/N Cancer type
Y/N Birth defect
Y/N Drug/alcohol abuse
Y/N mental illness/depression
Y/N Suicide attempt
Y/N Glaucoma
Y/N Heart disease/heart attacks
Y/N High blood pressure
Y/N High cholesterol
Y/N Stroke
Y/N Kidney Disease
Y/N Migraines
Y/N Seizures
Y/N Obesity
Y/N Has any family member died suddenly at less than 50 years of age of causes other than an accident?

Mother's Pregnancy History (with this child)

What month of pregnancy did you begin prenatal care?

Where?

Pregnancy History

# of pregnancies:

# of live births:

# of miscarriages:

# of abortions:

Problems during pregnancy, labor or delivery?

Type of delivery? (vaginal/C-section)

How long was your baby's hospital stay?

Child's Social History

Child lives with: (Mother/Father/Sibling/Other)

Who is the child's primary caretaker?

Name of school/day care?

Social service agencies involved with your family:

Y/N Does physical abuse occur in your home?

Y/N does verbal abuse occur in your home?

Behavior/Personal History

Y/N Do you have any concerns about your child's behavior?

Y/N Do you have concerns about how your child is developing or learning?

Y/N Are you satisfied with how your child is doing in school?

Y/N Does your child seem generally happy?

Health/Nutrition Habits

Y/N Do you have any concerns about your child's diet, eating habits, or growth?

Y/N Does child receive WIC?

Y/N Are there smokers in your home?

Y/N Do you have concerns that your child may be using tobacco, alcohol, or street drugs?

Child's favorite physical activity/exercise:

# of hours a day spent watching TV:

# of times child is read to each week:

# of days child missed school last year:

Y/N Do you have Syrup of Ipecac in your home?

Y/N Does child use car seat or seatbelt?

Y/N Does child wear a helmet when biking?

Y/N Is child alone at home after school?

Y/N Do you have a working smoke detector in your home?

Y/N Is there a gun in your home?

Comments: