

CHILD HISTORY (age 0-11)

CHILDS NAME:	DATE OF BIRTH:	AGE:	DATE:
MOTHER's NAME:	DATE OF BIRTH:	OCCUPATION:	
FATHER's NAME:	DATE OF BIRTH:	OCCUPATION:	
Address:			Phone:

BROTHERS

SISTERS

NAME BIRTHDATE

NAME BIRTHDATE

CHILD MEDICAL HISTORY

Has THIS child had any..... (if YES, explain on back)

- Problems after delivery?
- Serious illnesses or growth problems?
- Serious Accidents? Head Trauma? Broken Bones?
- Hospitalizations? _____
- Surgeries? _____
- Recurrent Infections? (ear, throat or lung functions)
- Allergies, Asthma?
- Chicken Pox? What Year? _____
- Bladder infection, kidney problems, undescended testicles, bed wetting?
- Seizures?
- Serious dental problems?
- Serious reaction to immunization?
- Learning or developmental problems?
- Speech, hearing or vision problems?
- Emotional / Behavioral problems?
- Has this child been hit, slapped, kicked or otherwise physically hurt by someone?

Does THIS child...

- Wear glasses?
- Take any medications?
- Take any vitamins?
- Take any Fluoride?

Where has child gone for prior medical care? _____

Date of last Dental Exam? _____

Date of last Medical Exam? _____

FAMILY MEDICAL HISTORY

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

Relationship

- Allergies/Asthma/Lung Disease? _____
- Tuberculosis? _____
- Blood Problems? _____
- Diabetes? _____
- Thyroid Disease? _____
- Cancer Type: _____
- Birth Defect: _____
- Druq / Alcohol Abuse?
- Mental illness / Depression / Suicide Attempt
- _____
- Glaucoma? _____
- Heart Disease / Heart Attacks _____
- High Blood Pressure? _____
- High Cholesterol? _____
- Stroke? _____
- Kidney Disease? _____
- Migraines? _____
- Seizures? _____
- Obesitv? _____
- Has any family member died suddenly at less than 50 years of age of causes other than an accident?

Other: _____

Other: _____

**MOTHER'S PREGNANCY HISTORY
WITH THIS CHILD**

What month of pregnancy did you begin Prenatal Care? _____

Where? _____

Pregnancy History:

Number of Pregnancies _____

Number of Live Births _____

Number of Miscarriages _____

Number of Abortions _____

Problems of pregnancy, labor, delivery _____

Type of Delivery: **VAGINAL** **C-SECTION**

How long was your babies hospital stay? _____ days

CHILD'S SOCIAL HISTORY

Child lives with: MOTHER

FATHER

_____ # SIBLINGS

_____ # OTHERS

Who is the child's primary caretaker? _____

Name of School/Daycare; _____

Grade: _____

Social Service agencies involved with your family: _____

Does Physical Abuse occur in your home? **Y** **N**

Does Verbal Abuse occur in your home? **Y** **N**

FEMALES ONLY (if applies)

Age of 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 Vaginal Exam? Reason: _____

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 your 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?

Childs favorite physical activity / exercise: _____

Number of hours a day spent watching TV...

0-1 1-2 3+

Number of times child is read to each week...

0-1 1-2 3+

Number of days missed school last year: _____

SAFETY

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

Y **N** Does child use a car seat or seat belt?

Y **N** Does child wear a helmet when biking or skating?

Y **N** Is child alone at home after school?

Y **N** Do you have a working smoke detector at home?

Y **N** Is there a gun in your home?

IMMUNIZATION HISTORY

DTaP (Diphtheria, Tuberculous and Pertussis forped)?
date: _____

IPOL (Polio)? _____

Rotavirus? _____

MMR (measles, mumps, Rubella)? _____

Hepatitis A: #1 _____ #2 _____

Hepatitis B: #1 _____ #2 _____ #3 _____

Flu Shot? _____

Pneumovax? _____

HIB (Hepatitis) _____

Chicken Pox (Varicella)? _____

Is the child **Currently taking any Medications?** **Y** (list below) **N**

Medication	Dose	How many times per day?	When Started?

Comments / Explanations
