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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

NAME	BIRTHDATE
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

SISTERS

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:________________	
☐ Drug / Alcohol Abuse?	____________
☐ Mental illness / Depression / Suicide Attempt ________________________________	
☐ Glaucoma?	____________
☐ Heart Disease / Heart Attacks	____________
☐ High Blood Pressure?	____________
☐ High Cholesterol?	____________
☐ Stroke?	____________
☐ Kidney Disease?	____________
☐ Migraines?	____________
☐ Seizures?	____________
☐ Obesity?	____________
☐ 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 Physcial 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 (Diptheria, Tuberculous and Pertussis for peds)? 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

____

____

____

____