CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH CHILD

During which month of pregnancy did you first see the doctor? _____ month			Where was baby born? _____		
How long was your pregnancy? _____ months			If baby was born at home, were blood tests for newborn screening done? ☐ YES ☐ NO		
Did you have any illnesses or problems during the pregnancy, including sexually transmitted or other communicable diseases?	YES	NO	Did you use any non-prescribed drugs like tobacco, alcohol, "street drugs" or over-the-counter or home remedies?	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficult or abnormal delivery or C-Section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the first week of life?	YES	NO	Did the baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐MALE ☐FEMALE ADOPTED? ☐YES ☐NO

BIRTH WEIGHT: _____POUNDS _____OUNCES LENGTH: _____ INCHES

Has your child ever had any of the following?					
Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating or refusing to eat	YES	NO
Tuberculosis or positive TB test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis or frequent Sore Throat	YES	NO	Skin problems	YES	NO
Problems with Eyes or Vision	YES	NO	Headaches or Dizziness	YES	NO
Problems with Ears or Hearing	YES	NO	Convulsions, Seizures, Epilepsy	YES	NO
Difficulty Breathing or Snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, Bronchitis, Pneumonia	YES	NO	Allergies	YES	NO
Anemia, Bleeding problems, Blood transfusions	YES	NO	Problems with Development or School performance	YES	NO
Stomachaches	YES	NO	Serious Illness or Accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or Hospitalization	YES	NO
Bladder or Kidney problems, Wetting self or bed	YES	NO	GIRLS – Has she started her periods?	YES	NO
Constipation	YES	NO	GIRLS – Are there problems with periods?	YES	NO

FAMILY HISTORY: Does child's mother(M), father(F), sister(S), brother(B), aunt(A), uncle(U), or grandparent(GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High Blood Pressure	
YES	NO	Epilepsy or Convulsions		YES	NO	Bleeding Disorder	
YES	NO	Mental Retardation		YES	NO	Tuberculosis	
YES	NO	Heart Disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or Breathing Problems	
YES	NO	Kidney or Urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or Joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

Mother: Age _____ Height _____

Father: Age _____ Height _____

HOUSEHOLD INFORMATION: Number of people in home: _____

Are both parents living in the home? ☐Yes ☐No

Does anyone in the home smoke or use alcohol or drugs? ☐Yes ☐No

Do you live in a: ☐House ☐Apartment ☐Mobile Home ☐Shelter ☐Home

Language spoken in the home: _____

Do you or your child have a hearing impairment? ☐Yes ☐No

Are Interpreter Services needed? (Staff Use Only) ☐Yes ☐No

PATIENT IDENTIFICATION:	Signature: _____ Date: _____ Relationship to Child: _____ Reviewer's Signature: _____ Date: _____

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