

## Child Health History

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Health: \_\_\_\_\_

Brother's Names & Ages: \_\_\_\_\_

Sister's Names & Ages: \_\_\_\_\_

Who takes care of this child most of the time? \_\_\_\_\_

### CHILD'S HEALTH HISTORY

Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Length of Pregnancy: \_\_\_\_\_ months

Normal Labor  Yes  No

Normal Delivery  Yes  No

Did child have problems after birth:  Yes  No

Surgeries: Date: \_\_\_\_\_ Type: \_\_\_\_\_

Date: \_\_\_\_\_ Type: \_\_\_\_\_

✓ Check if this child has had a problem with any of the following:

- Vision or Hearing
- Ear Infections
- Pneumonia or bronchitis
- Asthma or breathing problems
- Hay fever
- Seizures
- Bed wetting
- Anemia
- Kidney or bladder concerns
- Allergies, what kind?
- Other concerns: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### HEALTH CARE HISTORY

Name of Previous doctor or clinic: \_\_\_\_\_

Is this child taking any medications on a regular basis?  No  Yes

Immunizations up-to-date?  Yes  No  Not Sure

Date of last physical exam: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_

### FAMILY HEALTH HISTORY

✓ Check if family members have had:

- Diabetes
- High Blood Pressure
- Heart Disease
- Asthma or Hay Fever
- Allergies: \_\_\_\_\_
- Tuberculosis (TB)
- Epilepsy (Seizures)
- Cancer
- Sickle Cell Disease
- Misuse of Alcohol or Drug
- Depression or Mental Illness
- Violent Behavior
- Learning Disabilities
- Other: \_\_\_\_\_

### PARENTAL CONCERNS

Do you have concerns about this child's:

Behavior? \_\_\_\_\_

Development? \_\_\_\_\_

Nutrition? \_\_\_\_\_

Other? \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ Patient: \_\_\_\_\_ DOB: \_\_\_\_\_