

Health History - Child

Name _____ Birth date _____

Please list your main concerns:

What diagnoses or explanations have been given to you about your child? _____

Was there any event or illness that you or others feel brought on your child's symptoms? _____

Family History

Check if family history is unknown

Age

Health Problems

Age

Health Problems

Mother _____ Father _____

Sibling _____ Sibling _____

Sibling _____ Sibling _____

Maternal GM _____ Maternal GF _____

Paternal GM _____ Paternal GF _____

| YES | RELATIONSHIP | YES | RELATIONSHIP | YES | RELATIONSHIP |
|-----|----------------------|-----|------------------------------|-----|---------------------------|
| | Alcohol/Drug Problem | | Endocrine/Hormonal Imbalance | | Gastro intestinal Disease |
| | Allergy/Asthma | | High Blood Pressure | | Skin Disease |
| | Anemia | | High Cholesterol/Fat | | ADD/ADHD |
| | Arteriosclerosis | | Kidney Disease | | Anxiety |
| | Arthritis | | Liver Disease | | Depression |
| | Binge Eating/Bulimia | | Mental Illness | | Other... |
| | Bleeding Problem | | Obesity | | |
| | Cancer | | Stroke | | |
| | Diabetes | | Suicide | | |
| | Epilepsy/Seizure | | Thyroid Disease | | |
| | Heart Disease | | Tuberculosis | | |

Health History

Name _____ Birth date _____

Pregnancy: Any illnesses/complications? _____

Medications: _____

Any stressful life events during pregnancy? _____

Labor and Delivery: Any complications? _____

Mode Of Delivery: Vaginal spontaneous ___ Vaginal w/ forceps ___ Vaginal w/ suction ___
C-Section _____ Reason _____

Medications during Labor and Delivery: _____

Full Term _____ Premature _____ Weeks _____

Apgar Scores _____ 1 min. _____ 5 min. _____

Complications in newborn period: _____

Medications given to baby during hospital stay? _____

Past History Of Illness And Medical Problems

Surgery: List all surgery and approximate dates _____

Other hospitalizations and dates _____

Broken bones and other traumatic injuries (include all car accidents or concussions) _____

Emergency room visits (dates) _____

| YES | WHEN | YES | WHEN | YES | WHEN | YES | WHEN | YES | WHEN | | |
|-----|--|-----|------|----------------------|------|-----|-------------------------------------|-----|------|--------------------------------|--|
| | abdominal pain -chronic | | | cancer | | | endometriosis | | | menstrual prob- lem | |
| | acne | | | cataract | | | hay fever/allerg- ies | | | mental disease | |
| | AIDS | | | chemical sensitivity | | | hearing problem | | | migraine | |
| | allergies | | | chicken pox | | | heparitis | | | mononucleosis | |
| | amalgams/silver gfillings | | | chronic diarrhea | | | herpes | | | nervous condi- tion | |
| | anemia | | | chronic fatigue | | | hiatal hernia | | | neurologic problem | |
| | antibiotics more than once a year | | | colds, frequen | | | high blood pres- sure | | | overweight (20 lbs.) | |
| | anorexia | | | colic | | | high cholester- ol/triglycerides | | | panic attacks | |
| | anxiety | | | colitis | | | hives | | | pelvic infection | |
| | arthritis | | | congenital defect | | | hypoglycemia | | | peptic ulcer | |
| | asthma | | | constipation | | | hyperactivity | | | pneumonia | |
| | attantion problem | | | counseling | | | insomnia | | | premenstrual tension | |
| | back pain/strain | | | croup | | | jaundice | | | psychotherapy | |
| | bed wetting | | | depression | | | kidney infection | | | reactions to vac- cinations | |
| | blood clots | | | diabetes | | | kidney stones | | | reflux | |
| | breast lump | | | dyslexia | | | kidney problem | | | rheumatic fever | |
| | bronchitis | | | ear infection | | | learning dis- ability | | | root canal | |
| | bulimia (self in- duced vomiting | | | eczema | | | liver disease | | | scoliosis | |
| | scarlet fever | | | seizures | | | sexually trans- mitted disease | | | sinusitis | |
| | skin problem | | | sleep disorder | | | suicide attempt | | | syphilis | |
| | taken steroid (cortisone/predni- sone) | | | thrush | | | thyroid problem | | | tics | |
| | tonsillitis | | | tooth problems | | | urine problem | | | vaginitis | |
| | vision problem | | | warts | | | whooping cough | | | | |

Social History

Who lives in the home with your child? _____

Are any children in family adopted? _____ Pets in house? _____

Caregivers besides parents _____

List the people who are most important in your child's life: _____

Recent changes, losses, births, deaths, divorce, remarriage or move? _____

Recent travel? _____

Is your child involved in any sports, music or other activities? _____

Please describe: _____

What exercise does your child get on a regular basis? _____

Time spent watching TV _____ hours per week.

Time spent playing electronic games _____ hours per week.

Child's preferred free-time activities: _____

Our family spends time together regularly in these activities: _____

Do you, your child, or any family members practice any relaxation/stress management techniques? _____ If yes, Please describe: _____

Developmental History

Please give age when skills were mastered.

| | | |
|---------------------|-----------------------|------------------------|
| Sitting up _____ | Running _____ | Ride two-wheeler _____ |
| Crawling _____ | Jumping _____ | Put on clothing _____ |
| Pull to stand _____ | Walk down steps _____ | First words _____ |
| Walking _____ | Pedal _____ | Sentences _____ |

Describe any problems with the above skills: _____

Current school grade _____ Repeated any grades? _____

Class placement: Mainstream _____ Special Ed. _____ Other _____

Describe any Special Education services _____