SAMPLE

CHILD HEALTH HISTORY

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month
How long was your pregnancy? _____Months
Where was baby born? _____
If baby was born at home, were blood tests for newborn screening done? Yes No

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, "street drugs:, 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 difficulty/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: Male Female Is this child adopted? YES NO Birth Weight: _____pounds _____ounces Length: _____ inches

Has your child ever had (Please circle Yes or No):

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB Test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/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/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development of 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 Kidney Problems, Wetting self or bed	YES	NO	(GIRLS) Has she stared her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), 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:	Father:
Age:	_____	_____
Height:	_____	_____
Occupation:	_____	_____

HOUSEHOLD INFORMATION: Number of people in home _____
Are both parents living in the home? Yes No
Does anyone in the home smoke, or use drugs or alcohol? Yes No
Language spoken in the home: _____
Do you live in a: House Apartment Mobile Home Shelter Homeless

Patient Identification:

Signature: _____ Date: _____

Relationship to Child: _____

Reviewer's
Signature: _____ Date: _____
