Child Health History

Child's name:______________________________Date of birth:_______________Age:_________________

PREGNANCY & BIRTH

How was your child born? ____

Is this child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other:_____________________________

Please indicate any medical problems during pregnancy ☐ None ☐ Specify ____________________________

____

Delivery by: ☐ Vaginal birth ☐ Caesarean If Caesarean, why? ______________________

Birth weight:____________________Birth length:_____________APGAR score 1min.________5 min. _________

Please indicate any medical problems during the baby's newborn period: If premature, how early?_

____

Other problems:

____

____

NUTRITION & FEEDING

Was your child breastfed? ☐ No ☐ Yes If so, how long? _______________________________________

Has your child had any unusual feeding/dietary problems? ☐ No ☐ Yes If yes, specify: _________

____

Milk intake now: Type ☐ Cow's milk (☐ Nonfat ☐ 1%fat ☐ 2%fat ☐ Whole milk ☐ Soy milk ☐ Rice milk

Average ounces per day (Note: 8 ounces = 1 cup) _____________

SLEEP

Hours per night________________________Naps (number & length) ________________________

Any sleep problems? ____

DENTAL HISTORY

Has child been seen by a dentist? ☐ No ☐ Yes If so, how often?____________Date of last visit_____________

IMMUNIZATIONS/INFECTIOUS DISEASES

Please bring your child's immunization records to your appointment.

Has your child had: ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis

EXPOSURE/HABITS

Any Concerns about lead exposure? (old home/plumbing/peeling paint) ☐ No ☐ Yes

Has your child ever been exposed to anyone with tuberculosis? ☐ No ☐ Yes

Do any household members smoke? ☐ No ☐ Yes

TV Hours per day ________ Computer-hours per day ________ Video games- hours per day ________

Child Health History

SOCIAL HISTORY

Who lives at home?

Name Age Relationship

____
____
____

Are there guns in the home ☐ Yes, ☐ No

Are your child's parents: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced If divorced, when? ____________

Parent's occupation: Mother ______________ Father ___________________

Child care situation: Parents ___________ others (who and hours per day) _______________________

SCHOOL HISTORY

Did/does your child attend school or preschool? ☐ No ☐ Yes Elem/Middle/High ______________________

Circle one School name

Current Grade __________________ School Performance _________________________

PAST MEDICAL HISTORY

Please describe any major medical problems and their dates:

____
____
____

Hospitalizations/Operations (with dates): ____

____

Broken bones or severe sprains ____

FAMILY HISTORY

Please indicate family members (parents, siblings, grandparents, aunts or uncles) with any of the following conditions:

Alcoholism/Drug abuse____________ Heart disease _________________ High Cholesterol ______________

High blood pressure______________ Diabetes_______________________ Stroke_______________________

Depression______________________ Bleeding/clotting problems_______ Cancer, specify type____________

Asthma/hayfever/eczema__________ Other________________________

Parent/Guardian

Signature:__________________________________Date: ____________