Young Child Health History Form

Child's Name:_____
First Middle Last

Prior Pediatrician Name _____ Phone and Fax Number _____

GENERAL INFORMATION

What is the child's sex? ☐ Female ☐ Male
Child's Date of Birth_____ current age _____
Is your child **adopted**? ☐No ☐Yes If yes, at what age? _____
Who is filling out this form?
☐Mother

☐Father

☐Other guardian (please explain relationship to child) _____

☐Other (please explain) _____

The child's parents are:

☐Single ☐Married ☐Divorced ☐Separated but not divorced

☐Widowed ☐Living together but not married ☐Unknown

Main adult contact for child	Other adult contact for child
Name:	Name:
Relation to child: ☐ Mother ☐ Father ☐ Other: _____	Relation to child: ☐ Mother ☐ Father ☐ Other: _____
Address: ☐ Same as child's Street address: _____ _____ City: _____ State: _____ Zip: _____	Address: ☐ Same as child's Street address: _____ _____ City: _____ State: _____ Zip: _____
Home Phone:	Home Phone:
Cell Phone:	Cell phone:
Work Phone:	Work Phone:

TODAY'S HEALTH PROBLEMS

SEE NEXT PAGE

1. List your child's reason for visiting the clinic today.

☐ Routine checkup
☐ Immunizations (shots)
☐ A health problem (please specify)_____
☐ Switching doctors (last doctor _____)

2. Is your child taking any **prescription medicines**?

☐No. My child does not take any prescription medicines.
☐Yes - Please list the child's medicines below or ☐I brought my child's medicines.

Name of medicine	Amount / size of pill	How many pills or doses does your child take at
Example: Dexadrine	10 mg	__1__morning ____noon ____evening __1__bedtime
		____morning ____noon ____evening ____bedtime
		____morning ____noon ____evening ____bedtime
		____morning ____noon ____evening ____bedtime

(Please use the back of this form if you have more prescription medicine.)

3. What **over-the-counter medicines**, does your child take regularly?

☐ Vitamins
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None, my child does not take any over-the-counter medicines regularly.

MEDICAL HISTORY

4.Does your child have any medical problems?

☐ No (If no, go to question #5.)
☐ Yes (If yes, list below.)

Medical History	Diagnosed at age
Example: Asthma	2 years old

5. Does your child have any **allergic reaction (bad effect)** from any of the following? (Check all that apply.) SEE NEXT PAGE.

☐ Outside or Indoor allergies (for example: grass, pollen, cats …)
☐ Food Allergies (for example: peanuts, milk, wheat …)
☐ Medicine or shots (immunization). (Please list below.)
☐ No, my child has no allergies that I know of.

Medicine child is allergic to:	What happens when the child takes that medicine
Example: Amoxicillin	Diarrhea (runny poop)

PAST SURGICAL HISTORY

6.Have your child **ever** had surgery? (Check all that apply).

☐ Tonsils and/or Adenoids removed ☐ Tubes for ears

☐ Hernia Repair ☐Heart Surgery ☐Abdominal/Stomach Surgery

☐ Orthopedic Surgery (Broken bones) ☐ Other_____

F AMILY

7. Check all the people that the **child lives with**:

☐ Mother
☐ Father
☐ Brothers (how many? _____)
☐ Sisters (how many?_____)
☐ Other family members (list _____)
☐ Friends or other people (list_____)
☐ Animals ☐ Dogs (how many?_____) ☐ Cats (how many?_____)
☐ Other animals _____

8. What medical problems do people in the child's family have?

Family Member	Medical Problems
Mother:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems Other: _____

Father:	☐Depression ☐Anxiety (nerve) problems ☐Learning disability ☐Overweight ☐High blood pressure ☐Diabetes (sugar) ☐Cancer ☐Heart problems Other: _____
Sisters:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems Other: _____
Brothers:	☐ Depression ☐ Anxiety (nerve) problems ☐ Learning disability ☐ Overweight ☐ High blood pressure ☐ Diabetes (sugar) ☐ Cancer ☐ Heart problems Other: _____

SHOTS

9. Has your child received **immunizations (shots)** in the past?

☐ No

☐ Yes

If yes, have you given this office a copy of the immunization (shots) records?

☐Yes

☐No

If not, **please give us the name of the doctors' offices or clinics** where your child has received these shots so we can get the records.

Doctor's office/clinic name: _____

Doctor's office/clinic phone number:_____

ABOUT MOM WHEN PREGNANT (For children under the age of 1)

The following questions are about the mother of the child during pregnancy and birth.

If you do not know about the pregnancy of the mother, check here ☐ and go to question #15.

10. What was the general **health of the mother** during pregnancy?

☐ Excellent ☐ Good ☐F air ☐ Poor ☐ Unknown

11. Were any of the following used **during pregnancy**?

☐ Cigarettes

☐ Alcohol

☐ Illegal drugs (which ones? _____)

☐ Prescription drugs (which ones? _____)

☐ None of the above

12. Did the mother have any of the following **conditions or problems during pregnancy**?

☐ Preeclampsia (high blood pressure) ☐ Diabetes (sugar)

☐ Emotional stress ☐ Injury or serious illness

☐ Unexpected bleeding or spotting ☐ Other _____

13. **Was the birth**:

☐ On the due date

☐ Before the due date (by how much_____)

☐ After the due date (by how much_____)

14. **Was the birth:** ☐Vaginal? ☐C-Section (surgical cut in the tummy)?

15. **Were any of the following used**?

☐ Pain medicine during birth (epidural)

☐ Tool to help pull baby out (forceps or vacuum)

☐ None

16. Were there any **problems during the birth**? ☐ Yes ☐ No

If yes, please explain: _____

ABOUT THE CHILD AS A BABY (For children under the age of 2)

17. Was/is the child **breastfed**? ☐ Yes ☐ No If yes, how long_____

IN SCHOOL AND AT HOME

18. Does the child go to **school or daycare**? ☐ Yes ☐ No If yes, what is its name?

_____