HEALTH HISTORY FORM FOR PATIENTS

Today's Date:_____ Form Completed by: _____

Child's Name_____ DOB:_____ Sex: M F

Household: Please list all those living in the child's home

Name	Relationship to Child	Date of Birth	Health problems

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Birth History: □ Don't know birth history

Any prenatal or neonatal complications? _____ Explain_____

Was the baby born at term? ____ If not, at how many weeks?_____ Was the delivery □vaginal □ cesearean Birth weight _____

If delivery was cesearean, why?_____

Was a NICU stay required? ____ Explain_____

Was initial feeding □ formula □ breast milk How long breastfed? _____ Did baby go home with mom from hospital? _____

Prenatal exposures: Tobacco □ Yes □ No Alcohol □ Yes □ No Explain_____

Prenatal vitamins □ Yes □ No _____

Other medications or drugs _____ _____

General:

Does your child have any serious illnesses or medical conditions? □ Yes □ No Explain_____

Is your child on any medications or supplements? □ Yes □ No Explain_____

Has your child had any surgery? □ Yes □ No Explain_____

Has your child ever been hospitalized? □ Yes □ No Explain _____

Is your child allergic to any medications? □ Yes □ No Explain_____

Past History: Does your child have, or has your child ever had,

Chickenpox	□ Yes □ No □ Don't know When_____
Frequent ear infections, ear or hearing problems	□ Yes □ No □ Don't know Explain_____
Nasal allergies	□ Yes □ No □ Don't know Explain_____
Problems with eyes or vision	□ Yes □ No □ Don't know Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia	□ Yes □ No □ Don't know Explain_____
Any heart problem or heart murmur	□ Yes □ No □ Don't know Explain_____
Anemia or bleeding problem	□ Yes □ No □ Don't know Explain_____
Organ transplant	□ Yes □ No □ Don't know Explain_____
Malignancy/bone marrow transplant	□ Yes □ No □ Don't know Explain_____
Acid reflux	□ Yes □ No □ Don't know Explain_____
Constipation requiring doctor visits	□ Yes □ No □ Don't know Explain_____
Recurrent urinary tract infections and problems	□ Yes □ No □ Don't know Explain_____
Metabolic/Genetic disorders	□ Yes □ No □ Don't know Explain_____
Cancer	□ Yes □ No □ Don't know Explain_____
Kidney disease or urologic malformations	□ Yes □ No □ Don't know Explain_____
Bed-wetting (after 5 years old)	□ Yes □ No □ Don't know Explain_____
Sleep problems, snoring	□ Yes □ No □ Don't know Explain_____
Chronic/recurrent skin problems (ex. Acne, eczema)	□ Yes □ No □ Don't know Explain_____
Frequent headaches	□ Yes □ No □ Don't know Explain_____
Convulsions or other neurologic problems	□ Yes □ No □ Don't know Explain_____
Diabetes	□ Yes □ No □ Don't know Explain_____
Thyroid or other endocrine problems	□ Yes □ No □ Don't know Explain_____
High blood pressure	□ Yes □ No □ Don't know Explain_____
History of serious injuries/fractures/concussions	□ Yes □ No □ Don't know Explain_____
ADHD/anxiety/mood problems/depression	□ Yes □ No □ Don't know Explain_____
Developmental delay	□ Yes □ No □ Don't know Explain_____
Dental decay	□ Yes □ No □ Don't know Explain_____
For girls, problems with her periods	□ Yes □ No □ Don't know Explain_____
Has had her first period □ Yes □ No	Age of first period _____

Biological Family History: Have any family members had the following?

Childhood hearing loss	□ Yes □ No □ Don't know Who_____
Nasal allergies	□ Yes □ No □ Don't know Who_____
Asthma	□ Yes □ No □ Don't know Who_____
Congenital Heart Disease	□ Yes □ No □ Don't know Who_____
Childhood/adolescent onset seizures	□ Yes □ No □ Don't know Who_____
SIDS/Sudden death of a child or adolescent	□ Yes □ No □ Don't know Who_____
Childhood or adolescent cancer	□ Yes □ No □ Don't know Who_____
Tuberculosis	□ Yes □ No □ Don't know Who_____
Heart disease (before 55 years old)	□ Yes □ No □ Don't know Who_____
High cholesterol/takes cholesterol medications	□ Yes □ No □ Don't know Who_____
Blood problems (anemia, bleeding disorder)	□ Yes □ No □ Don't know Who_____
Liver disease	□ Yes □ No □ Don't know Who_____
Kidney disease	□ Yes □ No □ Don't know Who_____
Diabetes (before 55 years old)	□ Yes □ No □ Don't know Who_____
Bedwetting (after 10 years old)	□ Yes □ No □ Don't know Who_____
Mental illness/depression	□ Yes □ No □ Don't know Who_____
Developmental disability	□ Yes □ No □ Don't know Who_____