Health History Form

Today's Date: ____________________

Child's Full Name: ________________________________

Date of Birth: ____________________ Sex: M____ F ____

Parents' Full Names: ________________________________ Age ________

________________________________ Age ________

Is this child yours by Birth ____ Adoption ____ Step-child ____ Foster ____ Other________

Does or will the child attend daycare? ______________________

Name of School: ____

Maternal and Birth History:

Gestation: Full Term _______ Premature (#weeks) ______

Was this pregnancy normal? _______ Any complications? ______________________________

Place of Birth: ____

Type of Delivery: Vaginal ______ C-Section ______

If C-section, please explain why: ____

Birth Weight: ____pounds ____ounces Birth Length: __________ inches

After delivery did this child:

Have to stay in the hospital longer than the mother? Yes ____ No ____

If yes, please explain: ____

Have breathing difficulties? Yes ____ No ____

If yes, please explain: ____

Have jaundice? Yes ____ No ____

If yes, please explain: ____

Go to NICU? Yes ____ No ____

If yes, please explain: ____

Was or is the baby breast fed _____ or bottle fed _____ What formula? ___________________

Child's Past Medical History

Has your child ever been treated for or had problems with the following:

Asthma or Reactive Airway Disease	Yes___No___	____________________
Wheezing or Bronchiolitis/RSV	Yes___No___	____________________
Seasonal Allergies or Hayfever	Yes___No___	____________________
Eczema	Yes___No___	____________________
Food Allergy	Yes___No___	____________________
Recurrent Ear Infections	Yes___No___	____________________
Pneumonia	Yes___No___	____________________
Urinary Tract Infections	Yes___No___	____________________
Seizures	Yes___No___	____________________
Anemia (low iron)/Bleeding Problems	Yes___No___	____________________
Broken Bones	Yes___No___	____________________
Heart murmur or other heart problems	Yes___No___	____________________
Chicken Pox	Yes___No___	____________________
Attention problems/Learning difficulties	Yes___No___	____________________
Developmental Delays	Yes___No___	____________________
Toilet Training	Yes___No___	____________________
Behavior	Yes___No___	____________________
Speech	Yes___No___	____________________
Other	Yes___No___	____________________

Any medication allergies? What reaction did the child have? ______________________________

____

Any chronic medical conditions? ____

____

Any hospitalizations? ____

____

Any surgeries-including ear tubes, tonsillectomy, hernia repair (what dates)? ________________

____

See any specialists? (Who/Where) ____

____

Family History:

Do any blood relative family members have or have had any of the following:

		If yes, who?
Asthma	[ ]	______________________
Alcoholism/Drug Abuse	[ ]	______________________
Allergies	[ ]	______________________
Anemia/Blood disorders	[ ]	______________________
Crossed eyes	[ ]	______________________
Cancer	[ ]	______________________
High blood pressure	[ ]	______________________
Heart disease	[ ]	______________________
Thyroid disorder	[ ]	______________________
Diabetes	[ ]	______________________
Kidney disease	[ ]	______________________
Depression/Anxiety	[ ]	______________________
ADHD	[ ]	______________________
Migraine Headaches	[ ]	______________________
High cholesterol	[ ]	______________________
Genetic Disorders	[ ]	______________________

Social History

The patients' parents are:

Married _____ Divorced_____ Separated_____ Unmarried but living together_____

Who lives in the home?

Name	Age	Relationship
____________	_____	____________
____________	_____	____________
____________	_____	____________
____________	_____	____________
____________	_____	____________
____________	_____	____________