

CHILD AND FAMILY HEALTH HISTORY FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER: _____

PRESENT HEALTH CONCERNS: _____

MEDICINES/VITAMINS: _____

HERBS/HOME REMEDIES: _____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Where was your child born? _____

Is the child yours by: Birth Adoption Stepchild Other: _____

Please indicate any medical problems during pregnancy None Specify: _____

Delivered by Vaginal Birth Caesarean If Caesarean, why? _____

Birth weight: _____ Birth length: _____ APGAR score 1 min _____ 5 min _____

Please indicate any medical problems during the baby's newborn period None 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? _____

DEVELOPMENT

At what age did your child: Sit alone _____ Walk alone _____ Say words _____ Toilet train (daytime) _____

Girls only: Age at first menstrual period _____

DENTAL HISTORY: Has child been seen by a dentist? No Yes If so, how often? _____ Date of last visit _____

***IMMUNIZATION/INFECTIOUS DISEASES:** Please bring your child's immunization records to your appointment.

Has your child had: Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)

EXPOSURES/HABITS: Any concerns about lead exposure? (old home/plumbing/peeling paint) No Yes

Do any household members smoke? No Yes

TV-hours per day _____ Computer-hours per day _____ Video games-hours per day _____

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 with a check (☑) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcoholism												
Anemia												
Asthma												
Autoimmune Disorder												
Bleeding Disorder												
Cancer, Breast												
Cancer, Melanoma												
Cancer, Ovary												
Congenital Anomaly/Birth Defect												
Heart Attack/Heart Disease												
Depression												
Diabetes, on insulin shots												
Diabetes, not on insulin												
Eczema												
Food Allergy												
Genetic Disorder												
Hay Fever												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Mental Retardation or Learning Disability												
Stroke												
Substance Abuse												
Thyroid Disorders												
Tobacco Use												
Tuberculosis												
Death before age 56 for reason not listed												
Other:												
Other:												

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are your child's parents Married Unmarried Separated Divorced If divorced or separated, when? _____

Mother's Occupation _____ Mother's Employer _____

Father's Occupation _____ Father's Employer _____

Childcare situation Parents Others (specify who and hours per day) _____

Concerns about your child: Alcohol use Tobacco Sexual activity Aggressive behavior

Is violence at home a concern? No Yes Are there guns in the home? No Yes

SCHOOL HISTORY

Did/does your child attend school or preschool? No Yes

Current Grade _____ Name of School _____

Any concerns about school performance? _____

Any concerns about relationships with Teachers No Yes Students No Yes

If more than 4 years old: does your child have a best friend? No Yes

Sports/exercise: Type _____ How often? _____ How long (minutes) _____