

Child's name: _____

Allergies: _____

For the form below, mark with an "X" all that applies.

Social History:

With whom does the child live with most of the time:

- Both parents in the same household
 Father Stepmother Stepfather
 Mother Guardian Brother(s)/Sister(s)

Perinatal history:

Mother's pregnancies:

- Total number of pregnancies
 Number of full term
 Number of premature
 Number of fetal deaths

Problems during pregnancy with this child:

- High blood pressure Toxemia
 Diabetes Hepatitis Rh factor
 Vaginal bleeds X-rays S.T.D.
 Urinary infections Rubella Accident
 Premature labor Other

Problems at the time of birth with this child:

- Deformities Injuries Breathing
 Blueness Jaundice Oxygen
 Irritability Feeding Incubator days
 Rehospitalization/extra stays Infection
 Other

Family Health History: Check all that apply to the *immediate* family (parents, aunts/uncles, siblings, grand - parents)

- Diabetes Heart Disease Obesity High blood pressure Elevated cholesterol Cancer
 Kidney disease Blood disorder Tuberculosis Asthma Allergies Seizures
 Thyroid problems Mental illness Drug use Alcohol use Tobacco use Suicide
 Eating disorders Mental retardation Other

Child Health History:

Any problems since the birth of your child? Please list below:

Hospitalizations:

Please circle the face that matches the pain your child is having today.



- 0 NO HURT 1 HURTS LITTLE BIT 2 HURTS LITTLE MORE 3 HURTS EVEN MORE 4 HURTS WHOLE LOT 5 HURTS WORST

Do you have any concerns regarding domestic violence or child abuse/neglect? YES NO

Immunizations:

Have any been started? If yes, please list below, where done:

Records Requested

Primary Drinking Water:

- Well
 City/Municipal
 Contains Fluoride

Current Medications: List name(s) of medication(s) the child is currently taking. Include vitamins, supplements, herbs, and oxygen:

Have you ever had to avoid health care for your child due to any of the following:

- Transportation
 Money
 Inconvenient