YOUR CHILD'S HEALTH HISTORY – 7 MONTHS and OLDER

Dear Parents,
Please answer all the questions you can to give us as complete a record of your child as possible. Thank you.

PATIENT'S NAME _____ TODAY'S DATE ____ _____
Patient's Birthdate _____ Age _____ □ Male □ Female Birthplace _____ _____
RACE (check all that apply) □ American Indian or Alaskan Native □ Asian □ Black □ Hawaiian or Pacific Islander □ White □ Declined ETHNICITY □ Hispanic or Latino □ Non-Hispanic or Latino □ Declined
Primary Language spoken at home _____

HEALTHCARE HISTORY
Previous primary care physician: _____ Date of last visit: _____
Dentist: _____ Date of last visit: _____
Complementary care provider (chiropractor, acupuncturist, etc): _____

PARENTS' MAIN HEALTH CONCERNS FOR THIS CHILD: _____
_____
_____

FAMILY HISTORY (Circle those who live with this child)
Parent 1 _____ Parent 2 _____
Relationship _____Age____ Years in school ____Relationship_____ Age_____ Years in school ____
Occupation _____ Occupation _____
Parent 3 _____ Parent 4 _____
Relationship _____Age____ Years in school ____Relationship_____ Age_____ Years in school ____
Occupation _____ Occupation _____
List names, ages, sex and general health of child's brothers and sisters:
_____
_____

MEDICAL HISTORY
Check any of the following your child has had and their age at that time:
□ Emergency Room visit Age_____ _____
□ Broken bones Age_____ _____
□ Stitches Age_____ _____
□ Surgery Age_____ _____
□ Hospital overnight Age_____ _____
□ Specialist physician Age_____ _____

□ chicken pox	□ heart problem	□ bladder infection	□ fever seizure	□ cancer
□ chronic ear infection	□ anemia	□ kidney problem	□ diabetes	□ vision problem
□ hearing problem	□ excessive bruising	□ wetting pants	□ thyroid problem	□ speech problem
□ asthma	□ blood transfusion	□ skin problem	□ alcohol/drug use	□ dental problem
□ lung problem	□ abdominal pain	□ frequent headaches	□ behavior problem	□ snoring
□ pneumonia	□ constipation	□ frequent colds	□ learning problem	□ soiling pants
□ high blood pressure	□ diarrhea	□ convulsions/seizures	□ ADD, ADHD	□ mental illness

Has your child had any allergic reactions to any medicines, injections, foods, animals, insects, or plants? Please list:_____
_____

Does your child take medications? Please list:
_____
_____
_____

PREGNANCY, BIRTH AND NEWBORN HISTORY

1. Was this child born on time? No Yes
2. Was this baby born □ head first □ legs first □ C-section?
3. Did the mother have an illness during her pregnancy? Yes No
4. How old was the mother when the baby was born? _____ Years
5. Did this baby have any trouble starting to breathe? Yes No
6. Did this baby have any trouble while in the hospital? Yes No
7. How long did your baby stay in the hospital? _____ days
8. Did the mother have baby blues or depression after the child's birth? Yes No
9. Do you have friends or family you can call on when you need help? Yes No

DIET HISTORY

1. How long did your infant breast or bottle-feed? _____
2. What formula was used in the first year? _____ Problems? _____
3. Does your child have food allergies? _____ Yes No
4. Does your child like/eat meat? Amount per day: _____ Yes No
5. Does your child like/eat dairy products? Amount per day: _____ Yes No
6. Does your child like/drink juice? Amount per day: _____ Yes No
7. Does your child always eat breakfast? Yes No
8. Does your child take any dietary supplements, herbs, or health store products? Yes No
   Please list: _____

DEVELOPMENTAL HISTORY

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did he/she say words by the time he/she was 18 months old No Yes
4. Is your child doing well in school? Yes No
5. Does your child get along well with other children? Yes No
6. Does your child get along well with the family? Yes No
7. Is your child receiving special services at school? Yes No
8. Is your child receiving behavioral health or mental health services? Yes No
9. Has your child ever lived with a family beside his/her parents? Yes No

ENVIRONMENTAL HISTORY

1. Does your child live in a house built before 1960? Yes No
2. Does your child drink water that has fluoride in it? Yes No
3. Do you have guns in your house? Yes No
   If yes, are they locked up? Yes No
4. Is anyone who lives in the home a smoker? Yes No
5. Does your child attend daycare? Yes No
6. Has your child traveled outside of the USA? Yes No
7. Has your child been exposed to a person with tuberculosis? Yes No

Do any close family members (child's biological mother, father, grandmother, grandfather, brothers, sisters, aunts, uncles, nieces, nephews) have any of the following health conditions? Please note which family member.

□ deafness before age 20	□ high cholesterol	□ bedwetting after age 10	□ frequent fainting
□ allergies	□ anemia	□ convulsions/epilepsy	□ thyroid problems
□ asthma	□ bleeding disorders	□ alcoholism	□ vision problem before age 12
□ anesthesia problems	□ liver problems	□ drug abuse	
□ heart attacks	□ kidney disease	□ mental illness	□ cancer
□ tuberculosis	□ diabetes	□ mental retardation	
□ high blood pressure	□ immune problems, HIV/AIDS		