YOUR CHILD'S HEALTH HISTORY – ALL AGES

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) □ White □ American Indian or Alaskan Native □ Asian □ Black
□ Hawaiian or Pacific Islander □ 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: _____ Behavioral, Mental Health: _____
Complementary care provider (chiropractor, acupuncturist, etc): _____

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:
_____
_____

PREGNANCY, BIRTH AND NEWBORN HISTORY **(Please fill in if child is less than one year old)**

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. Did the mother drink alcohol or use drugs during her pregnancy?	Yes	No
5. How old was the mother when the baby was born?	_____ Years	
6. Did this baby have any trouble starting to breathe?	Yes	No
7. Did this baby have any trouble while in the hospital?	Yes	No
8. How long did this baby stay in the hospital?	_____ days	
9. Did the mother have baby blues or depression after the child's birth?	Yes	No
10. Do you have friends or family you can call on when you need help?	Yes	No

DIET HISTORY

1. How long did your baby 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 have any special dietary needs? _____	Yes	No
5. Does your child take any dietary supplements, herbs, or health store products?	Yes	No
Please list: _____		

PLEASE COMPLETE OTHER SIDE

DEVELOPMENTAL HISTORY

1. At what age did your child sit alone? _____ Walk? _____
2. Did he/she say words by the time he/she was 18 months old — No Yes
3. 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? List: _____ — Yes No
8. Is your child receiving behavioral health or mental health services? List: _____ — 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

MEDICAL HISTORY

Check any of the following your child has had and their age at that time:

□ Emergency Room visit Age_____ _____
□ Broken bones Age_____ _____
□ Surgery Age_____ _____
□ Hospital overnight 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

FAMILY MEDICAL HISTORY

Do any close family members (biological mother, father, grandmother, grandfather, brothers, sisters, aunts, uncles, nieces, nephews) have any of the following? Please note who has the condition.

	Who?		Who?		Who?
□ 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	_____
□ intellectual disability	_____	□ high blood pressure	____	□ immune problems, HIV/AIDS	_____

PLEASE COMPLETE OTHER SIDE