

# Health History

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SEX \_\_\_\_\_

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Father's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Occupation \_\_\_\_\_

If adults in the household work outside the home, what childcare arrangements are made for this child? \_\_\_\_\_

## A. Pregnancy and birth: (circle "no" or "yes" leave blank if uncertain)

1. Did the mother have any illness during the pregnancy?..... no      yes
2. Were any other medications other than vitamins and iron taken during pregnancy?..... no      yes
3. Was the baby born on the calculated due date?..... yes      no
4. What was the birth weight?..... \_\_\_\_\_
5. Did the baby have any trouble starting to breathe?..... no      yes
6. Did the baby have any trouble while in the hospital?(jaundice, infection, other?)..... no      yes

## B. Past Medical History: (circle "no" or "yes" leave blank if uncertain)

1. Where has your child gone for check-ups until now?..... \_\_\_\_\_
2. Date of last check-up..... \_\_\_\_\_
3. Date of last dental check-up(if applicable)..... \_\_\_\_\_
4. Has your child had allergic reactions to any medications, food, insect bites, or immunizations?..... no      yes
5. Any hospitalizations other than for birth?..... no      yes
6. Any serious injuries?..... no      yes  
If "yes" please give details \_\_\_\_\_
7. Are any medications taken regularly?..... no      yes  
If "yes" please list \_\_\_\_\_

## C. Family History

1. Are the child's parents both in good health?..... yes      no
2. Circle any diseases that this child's parents, grandparents, brothers, sisters or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, cancer, AIDS, or learning disabilities.
3. List age, sex and general health of brothers and sisters \_\_\_\_\_
4. Have any of your children died?..... no      yes

## D. Feeding and Nutrition

1. Is your child's appetite usually good?..... yes      no
2. Is it good now?..... yes      no
3. Was there severe colic or any unusual feeding problem during the first three months?..... no      yes
4. Do any foods seem to disagree with him/her?..... no      yes
5. For the first 6 months, was he/she (is he/she) breast or bottle fed? \_\_\_\_\_
6. If still on formula, which one do you use? \_\_\_\_\_