Child's Health History Form · Please Give To Nurse When Called

Name: **Today's Date:**

Does child have allergies? ☐Yes - ☐No; If yes then specify:

Surgical History of Child (Please Check All That Apply)

☐ Eye Surgery	☐ Heart Surgery	☐ Ear Tube Insertion	☐ Abdominal Surgery	☐ Orthopedic Surgery
☐ Removal Of Adenoids	☐ Heart Valve Repair	☐ Ear Tube Removal	☐ Hernia Repair	☐ Appendix Removal
☐ Removal Of Tonsils	☐ Sinus Surgery	☐ Other:		☐ **No Prior Surgery**

Personal Medical History of Child

☐ Headache/Migraine	☐ Asthma	☐ Reflux	☐ Kidney Stones	☐ Anxiety
☐ Epilepsy	☐ Pneumonia	☐ Heart Disorders	☐ Arthritis	☐ Depression
☐ Allergies	☐ Tuberculosis	☐ Diabetes Mellitus	☐ Easy Bleeding	☐ HIV
☐ Chronic Sinusitis	☐ Sleep Apnea	☐ Hypertension	☐ Anemia	☐ High Cholesterol
☐ Thyroid Disorders	☐ Chicken Pox – Date:			

☐Yes - ☐No Have you had a blood transfusion? When? Where? Reaction?

☐Yes - ☐No Previous Hospitalizations	☐Yes - ☐No Previous Emergency Room Visits	☐ Previous EKG. Date:	☐ Previous EKG. Date:

Child's Social History (Check All That Apply)

☐ Alcohol Use	☐ Do You Smoke?	☐ Caffeine Use	☐ Recreational Drug Use
Drinks per day: _____	Cigarette packs per day: _____	Cups Of Coffee/Day: _____	☐ Regular Exercise
☐ Alcohol Use Disrupting Home	☐Yes - ☐No Exposed to second smoke?	Cups of Tea/Day: _____	
☐ Household includes: father, mother, stepfather, stepmother, # of sisters_____ # brothers ____, Others:	☐ Child Living in: Apartment, foster home, private residence, homeless shelter, other: _____	☐ Parents, step family, Relatives, Other _____ _____	☐ Home Environment: High Risk neighborhood, domestic violence, second hand smoke, guns in home, fear of occupants, other_____

Family History of Child

Condition	Father	Mother	Brothers	Sisters	Sons	Daughters	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Infant Deaths	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Retartation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ **Other** ☐ **Adopted: Family History Unavailable**

Girl's History

Pads used in 24hr:	☐ Light Bleeding	Flow Duration	☐ Regular Cycles	Last Pap Smear:
☐ Tampon use	☐ Heavy Bleeding	Age of first period:	☐ Irregular Cycles	☐ Past Abnormal Pap
Pregnancies (Gravid):	Deliveries (Para):			☐ Menopausal