HOT SPRINGS HEALTH PROGRAM

Child Health History Update

Date:____/____/____

Patient Name:

Likes to be called (nickname):

Name of person filling out form & their relationship to child:
Name: _____Relationship: _____

Date of Birth: ____/____/____ Sex: ____M ____F

PREGNANCY & BIRTH HISTORY

Is the child adopted? ___No ___Yes
Birth Weight: ____ pounds ____ounces
Was baby born on time? ___No ___Yes ____Weeks
Was the birth: ____Vaginal ____C-Section, If C-Section, why?
_____
Any problems during pregnancy or at birth? ___No ___Yes
If yes, explain: _____
_____
During pregnancy did mom: Use tobacco? ___No ___Yes
Drink Alcohol? ___No ___Yes
Use drugs or other medications? ___No ___Yes What? _____
Use prenatal vitamins? ___No ___Yes
Did baby have any problems of need to stay in NICU? __No ___Yes
If yes, explain:_____
The initial feeding for the baby was: ___Formula ___Breast Milk
How long did baby breastfeed: _____
Did baby go home with mom? ___No ___ Yes
If no, explain:_____

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child: _____
_____
Are there siblings not listed? If so, list names, ages and where they live: _____
What is your child's living situation? Biological mother & father ___ ___Joint Custody___Single Custody ___Foster Care
If one or both parents are not living in the home, how often does the child see the parent not in the home? _____
Tobacco use in family? ___No ___Yes /If so, who?_____
Smokes in the home?__No ___Yes/In the car?__No ___Yes
Are there guns in the home? __No __Yes/Are they locked? _No_Yes
Does child attend…Daycare: __No __Yes/Preschool: __No __Yes
School: __No __Yes

***For teens only*- Are any of the following problems present:**
Alcohol or other substance abuse: ___No __Yes
Caregiver problems or issues: ___No __Yes
Loss of a family member: ___No __Yes
Do you feel safe in your relationship: ___No __Yes

CHILD'S HEALTH HISTORY

Has the **child** ever had: **Date:**
Hospitalizations ___No ___Yes _____
Serious Injuries/Broken Bones ___No ___Yes _____
Surgeries/Type of Surgeries ___No ___Yes _____
_____
Allergies to Medications/Other allergies:___No ___Yes _____
Type _____
Chicken Pox…….. ___No ___Yes _____
Frequent Ear Infections ……___No ___Yes _____
Vison/Hearing Problems….. ___No ___Yes _____
Nasal Allergies …… ___No ___Yes _____
Asthma/Lung Problems ….. ___No ___Yes _____
Any Heart Problems/Murmur ___No ___Yes _____
Anemia/Sickle Cell …… ___No ___Yes__ _____
Bleeding Problems/Transfusion ___No ___Yes _____
Immune Problems/HIV …… ___No ___Yes _____
Cancer ___No ___Yes ___Type_____
Frequent Stomach Aches requiring Doctor visits?
___No ___Yes _____
Constipation ……. ___No ___Yes _____
Bladder Infections/Kidney Disease __No __Yes_____
Birth Defects …… ___No __Yes _____
Metabolic/Genetic Conditions … ___No __Yes _____
Sleep/Snoring/Bed Wetting Issues __No __Yes _____
Chronic Skin Problems/Eczema .___No ___Yes _____
Frequent Headaches ……___No __Yes _____
Seizures/Neurological Problems ___No ___Yes _____
Obesity…….___No __Yes _____
Diabetes …….. ___No __Yes _____
Thyroid/Endocrine Problems …. ___No __Yes _____
High Blood Pressure …… ___No __Yes _____
Alcohol/Drug Use/Tobacco ……..___No __Yes_____
ADHD/Anxiety/Mood/Depression ___No __Yes_____
Developmental Delay/Disability ... ___No __Yes_____
Dental Decay/Cavities ……... ___No __Yes _____
History of Family Violence/Abuse ___No __Yes _____
Sexual Infections/Pregnancy …….. ___No __Yes_____
Other: _____ _____

BIOLOGICAL FAMILY HEALTH HISTORY

Please identify if **anyone in the family of the child** (**M**-Mother, **F**-Father, **SIB**-Sibling, **MGM**-Maternal Grandmother, **MGF**-Maternal Grandfather, **PGM**-Paternal Grandmother, **PFG**-Paternal Grandfather) had……..

Who?

Childhood Hearing Loss .. ___No ___Yes _____
Nasal Allergies …… ___No ___Yes _____
Asthma…… .___No ___Yes_____
Bowel Problems …….. ___No ___Yes_____
Lung Problems …… ___No ___Yes _____
Heart Disease ……...___No ___Yes _____
High Blood Pressure/Stroke ___No ___Yes _____
High Cholesterol …….___No ___Yes _____
Takes Cholesterol Medication ___No ___Yes _____
Anemia/Sickle Cell…… ___No ___Yes _____
Bleeding Problems……. ___No ___Yes _____
Dental Decay/Cavities …… ___No ___Yes _____
Cancer……. ___No ___Yes (Type) _____
_____
Liver Disease/Hepatitis …… ___No __Yes_____
Kidney Disease ……..___No ___Yes _____
Diabetes/High Blood Sugar…. ___No ___Yes _____
Obesity……. ___No ___Yes _____
Seizures/Epilepsy……. ___No ___Yes _____
Convulsions…….. ___No ___Yes _____
Alcohol/Drug Abuse ……. ___No ___Yes _____
Bone/Muscle Problems ……. ___No ___Yes _____
Mental Illness/Depression ……..___No ___Yes _____
ADHD/ADD ……__No ___Yes _____
Mental Retardation …… ___No ___Yes _____
Immune Problems/HIV/AIDS… ___No ___Yes _____
Other family history not mentioned above…….
_____
_____
_____