TRI-COUNTY CAA – HEALTH CENTER

PEDIATRIC HEALTH HISTORY SHEET

Do you need any help to complete this form? NO_____ YES____ We will be happy to assist you if needed.

Child's Full Name _____ DOB_____ Preferred Name _____

Parent/Guardian Full Name	Relationship	Education, last year completed

Brothers/Sisters	Age	Education, last year completed	Brothers/Sisters	Age	Education, last year completed

A. Pregnancy and Birth

1. During the pregnancy, who was the regular doctor? _____
2. When was the first pre-natal visit? _____
3. Were their any problems during the pregnancy?..... YES NO
   If yes, please explain _____
4. During the pregnancy, was there tobacco use?..... YES NO
   If yes, how much _____
5. During the pregnancy, was there alcohol use?..... YES NO
   If yes, how much _____ how often _____
6. Did the baby arrive late?..... YES NO
   If yes, how late _____
7. Did the baby arrive early?..... YES NO
   If yes, how early _____
8. Birth weight _____ Birth length _____
9. Describe any problems with the baby at or after birth _____
   _____

B. Feeding and Nutrition Do you have any concerns about your child's eating habits or nutrition? YES NO

If yes, please explain _____

C. Development Do you have any concerns regarding your child's development?..... YES NO

If yes, please explain _____

D. Past illnesses, miscellaneous problems

Check any of the following that your child has had in the past or is currently experiencing including date it first started:

❑ Chicken Pox	❑ Problems with teeth	❑ Lead Poisoning	❑ Urinary Tract Infections # ____ per year
❑ Diabetes	❑ Tuberculosis	❑ Serious Accidents/Falls	❑ Frequent Ear Infections
❑ Cancer	❑ Seizures	❑ Blood Disorders	❑ Growth Problems
❑ Asthma	❑ Vision Problems	❑ Hearing Problems	❑ Cystic Fibrosis
❑ ADHD/ADD	❑ Heart Problems	❑ Pneumonia, more than once	❑ Frequency Cold & Sore Throat

Please explain any items check above and/or list any problems not included above: _____

_____

E. Hospitalizations (including overnight stays) and Operations

Specify	Date	Reason	Name of Hospital

F. List any medications that child is presently taking (including vitamins, over the counter meds, respiratory therapy related meds)

Medication	Dose	Frequency	C*
			❑
			❑
			❑
			❑

Medication	Dose	Frequency	C*
			❑
			❑
			❑
			❑

** To be completed by the provider. Check "C" if med is to be continued and transfer information to Med Flow Sheet.*

G. List any allergies that your child has (including latex, if applicable) and the reaction: _____

_____

H. Family/Social History

1. Have any of your children died?..... YES NO

   If yes, what was the cause of death? _____

2. Circle any of the following diseases that family members have or have had. (Include mother, father, grandparents, siblings, aunts, uncles, etc.)

	Member of the Family	Mother's or Father's side
Tuberculosis		
Diabetes		
Seizures		
Heart disease/High blood pressure		
High Cholesterol		
Mental Illness		
Hearing/Vision Problems		
Inherited Problems		
Alcohol or Drugs Addiction		
Cancer (type)_____		
Asthma		
Allergies		
Anemia		
Other_____		

Housing (check all that apply):
❑ Own ❑ Rent ❑ Public Housing ❑ Foster Family ❑ Homeless ❑ Shelter ❑ Living with Friend ❑ Living with Relatives
Does any one at home smoke? ❑ NO ❑ YES: ❑ inside ❑ outside ❑ inside and outside
If yes, who? _____ How much? _____

Do you have any pets at home? ❑ NO ❑ YES If yes, what kind? _____

I. School Information

1. School name _____
2. Does he/she get along with other children?..... YES NO
3. Do you feel your child has problems at school?..... YES NO
4. Does the child's teacher feel he/she has problems at school?..... YES NO
5. Has your child had any special evaluation or is he/she receiving any extra school support?..... YES NO

   If yes, please explain _____

J. Concerns

1. Are there any problems you would like to discuss?..... YES NO

   If yes, please explain _____

2. Are there health topics that you /child would like to learn about?_____

   If yes, is there anything about how you/your child learns that would be helpful for us to know (cultural & religious beliefs)? YES NO

   If yes, please explain_____

3. Do you or your child have any special needs (physical, emotional, or learning styles)?..... YES NO

   If yes, please explain _____

How do you /does your child learn best? ❑ Read  ❑ Hear  ❑ Watch  ❑ Do 

What is your primary language?_____ What language do you want used for educational material? _____

Signature of individual filling out form: _____ Relationship_____ Date: _____

Provider review _____ **Date:** _____

❑ Check if Translator used Name of Translator _____