5 – 18 Years Health History Form

Name_____ □Male□Female DOB_____

Previous Last Name (if different than above)_____

Mother's Name_____ DOB_____ Occupation_____

Father's Name_____ DOB_____ Occupation_____

Please list all the people in your household other than the patient:

Name	*Date of Birth*	*Relationship to Patient*

Birth History

Place of Birth_____ Birth Weight_____

During pregnancy did mother use alcohol or street drugs? □No□ Yes *Explain*_____

Was there any problems during pregnancy or delivery? □No□ Yes *Explain*_____

How many weeks pregnant were you when your baby was born? _____

How many days was the baby in the hospital? _____

Past Medical History

Please list any conditions in and explain.

Has child had any surgical procedures?□No□ Yes _____

Has child been hospitalized *overnight* for any condition? □No□ Yes *Explain*_____

Does child have any allergies?□No□ Yes *Explain*_____

Has child been diagnosed with any *chronic* medical problems?□No□ Yes *If yes, with whom and where:*

_____

Has child been diagnosed with any *behavioral* problems?□No□ Yes _____

Does child currently take any medications daily? □No□ Yes _____
(Prescription OR over the counter)

Does child have any problems with □ Vision □ Hearing □ Speech _____

Family History

Please mark any conditions in childs' extended family AND explain. (grandparents, aunts, uncles, cousins, sibling)

□ Allergies □ Asthma □ Lung disease □ Tuberculosis _____

□ Birth defect □ Cancer _____

□ Diabetes □ Kidney disease □ Thyroid disease _____

□ Alcohol use □ Alcohol abuse □ Illegal drug use _____

□ Heart attack □ Heart disease _____

□ High blood pressure □ High cholesterol _____

□ Mental Illness □ Depression _____

□ Obesity □ Overweight _____

□ Seizures □ Epilepsy _____

Family History *continued*

Please mark any conditions in childs' extended family AND explain. (grandparents, aunts, uncles, cousins, sibling)

Have any of the child's siblings died? ☐ Yes ☐ No _____

Any family member under the age of 50 who died suddenly of causes other than *accident OR violence?* _____

Social History

Relationship of Parents ☐ Married ☐ Divorced ☐ Separated
☐ Not married but living together ☐ Not married, not living together

Do you attend a church and have a religious preference? ☐ Yes ☐ No If yes, what?_____

Does child go to daycare or a babysitter regularly? ☐ Yes ☐ No If yes, where?_____

Any major changes or stresses in child's life recently? ☐ Yes ☐ No If yes, what?_____

Does anyone smoke in the home? ☐ Yes ☐ No ☐ Inside ☐ Outside

Safety

Does your child use a booster seat or seat belt in cars? ☐ Yes ☐ No

Does your child wear a helmet when riding a bike, scooter, or roller blades? ☐ Yes ☐ No

Is there a gun/firearm/weapons in the house ☐ Yes ☐ No

Is there verbal /physical fighting occuring in the house? ☐ Yes ☐ No