0-4 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*____________________________

Were 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 *Explain*____

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 chronicmedical problems, serious acute illnesses or injuries or ever been hospitalized?
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' family AND explain. (Parents, grandparents, aunts, uncles, cousins, and siblings)

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?______________________

Will child go to daycare or a babysitter regularly? Yes No ______________________________

Does anyone smoke in the home? Yes No Inside Outside

Safety

Does your child use a car seat in cars? Yes No

Is your home child proofed? Yes No

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

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