UNICARE COMMUNITY HEALTH CENTER

CHILD HEALTH HISTORY (BIRTH – 11 YEARS OLD)

PATIENT IDENTIFICATION

FIRST NAME _____ LAST NAME _____ DOB _____

PARENT/LEGAL GUARDIAN IDENTIFICATION

FIRST NAME _____ LAST NAME _____ DATE _____

SIGNATURE _____ RELATIONSHIP TO CHILD _____

HISTORY OF PREGNANCY WITH CHILD

During which month of pregnancy did you first see the doctor? _____ month			If the baby was born at home, were blood tests for newborn screening done?	YES	NO
How long was your pregnancy? _____ months			Where was the baby born? _____		
Did you have any illnesses or problems during the pregnancy, including sexually transmitted or other communicable diseases?	YES	NO	Did you use any non-prescribed drugs like tobacco, alcohol, "street drugs" or over-the-counter or home remedies?	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficult or abnormal delivery or C-Section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the first week of life?	YES	NO	Did the baby receive any shots for Hepatitis B?	YES	NO

CHILD HISTORY

GENDER: ☐ MALE ☐ FEMALE **ADOPTED?** ☐ YES ☐ NO **BIRTH WEIGHT:** _____ POUNDS _____ OUNCES **LENGTH:** _____ INCHES

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING?					
Measles, Chickenpox, Mumps, Rubella	YES	NO	Muscle, joint or bone problems	YES	NO
Tuberculosis or positive TB test	YES	NO	Skin problems	YES	NO
Tonsillitis or frequent Sore Throat	YES	NO	Headaches or Dizziness	YES	NO
Problems with Eyes or Vision	YES	NO	Convulsions, Seizures, Epilepsy	YES	NO
Difficulty Breathing or Snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, Bronchitis, Pneumonia	YES	NO	Allergies	YES	NO
Anemia, Bleeding problems, Blood transfusions	YES	NO	Problems with Development or School performance	YES	NO
Stomachaches	YES	NO	Serious Illness or Accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or Hospitalization	YES	NO
Bladder or Kidney problems, Wetting self or bed	YES	NO	**GIRLS** – Has she started her period?	YES	NO
Constipation	YES	NO	**GIRLS** – Are there problems with her periods?	YES	NO
Vomiting after eating or refusing to eat	YES	NO			

FAMILY HISTORY: Does Child's mother(M), father (F), sister (S), brother (B), aunt(A), uncle (U), or grandparent (GP) have any of the following?

			WHO?				WHO?
YES	NO	Diabetes		YES	NO	High Blood Pressure	
YES	NO	Epilepsy or Convulsions		YES	NO	Bleeding Disorder	
YES	NO	Mental Retardation		YES	NO	Tuberculosis	
YES	NO	Heart Disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or Breathing Problems	
YES	NO	Kidney or Urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or Joint problems		YES	NO	Ear disorder	

PARENT INFORMATION

Mother: Age _____ Height _____ **Father:** Age _____ Height _____

HOUSEHOLD INFORMATION

Number of people in the household: _____	Are both parents living at home?	YES	NO
Language spoken at home: _____	Does anyone in the house smoke or use alcohol/drugs?	YES	NO
Do you live in a: ☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter	Do you or your child have a hearing impairment?	YES	NO

OFFICE USE ONLY:

REVIEWED BY _____ DATE _____ Are Interpreter Services needed? (Staff Use Only) ☐ Yes ☐ No