Pediatric Wellness Center of Amarillo

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CHILD HEALTH HISTORY

Child's Name ____________________________ DOB____________ Today's Date________________

Your child's overall health, as well as any medications you child takes, could have an important relationship with the care your child receives. Please answer each of the following questions completely.

SOCIAL INFORMATION

Please circle "yes" to any problems your child currently has or has ever had.

Thumb Sucking	Y	N		Developmental delays	Y	N
Dental Problems	Y	N		Nightmares/Sleep Problems	Y	N
Speech Problems	Y	N		Alcohol/ Drug abuse	Y	N
Toilette Training Problems	Y	N		Feeding/Eating Problems	Y	N
Bed Wetting	Y	N		# of meals/day ____# Snacks_____	Y	N
Diarrhea or Constipation	Y	N		Does your child take vitamins?	Y	N
Irritable/Temper Problems	Y	N		Has your child ever eaten dirt,paint?	Y	N
Discipline Problems	Y	N		Does your child get along with other children?	Y	N
Emotional Problems	Y	N		Is your child doing well in school?	Y	N
Eye Problems	Y	N		Age and sex of siblings :		
Hearing Problems	Y	N				

Does your child live in a blended family? _____ Yes _____ No

Are the parents ____ married ______ divorced

PREGNANCY/BIRTH HISTORY – Previous Pregnancies _______ Delivered at: _____________

Child's birth weight __________ Delivery: ____ Vaginal ____ C-Section (elective or emergency)

Was your child born more than two weeks early or late? ___ Yes ____ No

Was your child breast fed? ___ Yes ___ No Age of discontinued ________

Did the mother use cigarettes, alcohol, drugs or medications during the pregnancy? ________________

Did the mother have any health problems / illnesses during the pregnancy? ___ Yes ____No

Did the mother have any maternity leave __________ if yes: how long?____________

PAST MEDICAL/SURGICAL HISTORY

Has your child every had ? (Please circle Yes or No

Mumps/measles	Y	N		Eczema/Skin Problems	Y	N		Diabetes	Y	N
Chicken Pox	Y	N		Heart Murmur	Y	N		Rheumatic Fever	Y	N
Pneumonia	Y	N		Congenital Heart Defect	Y	N		Emotional Disorder	Y	N
Asthma/Wheezing	Y	N		Convulsion/Epilepsy	Y	N		Handicap/Disability	Y	N
Allergies	Y	N		Cancer	Y	N		HIV/AIDS	Y	N
Frequent Ear Infections	Y	N		Hepatitis	Y	N		Sexually Tansmitted Disease	Y	N
Frequent Colds	Y	N		Abnormal Bleeding	Y	N		Suicide Attempts	Y	N
Frequent Sore Throats	Y	N		TB	Y	N		Rheumatic Fever	Y	N
Croup	Y	N		Trauma /Fractures	Y	N		Bladder / Kidney Infections	Y	N

Please explain any medical problems that your child has had : ________________________________

____

Please list any hospitalizations, serious or unusual illness which you child has experienced – including dates:

____

____

MEDICATIONS /SUPPLEMENTS

____

____

ALLERGIES – Please list all allergies, sensitivities, and /or reactions to any drugs / foods

____

____

FAMILY HEALTH HISTORY

	Asthma			Diabetes			Kidney Problems
	Alzheimer			High Blood Pressure			Sickle Cell Disease
	Alcoholism			Stroke			Cystic Fibrosis
	Blood Disorders			Migraines			Hearing Problems
	Heart Disease			Obesity			Visual Problems
	Cancer			Seizures			Depression
				Celiac Disease			

Signature of Parent /Guardian ______________________________ Date __________________________