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?_____

Mother's age _____: Father's age _____ (at time of Child's birth)

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 Transmitted 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 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
	Coronary Artery Disease		Obesity		Visual Problems
	Cancer		Seizures		Depression
			Celiac Disease		

Are the parents healthy? Mother: Y / N _____ Father: Y / N _____

WHAT DO YOU EXPECT FROM US?

_____

ANY PARTICULR COCNERNS?

Signature of Parent / Guardian _____ Date: _____