



CHILD HEALTH HISTORY

Name: _____ **DOB:** _____
Sex: _____ **Age:** _____ **Informant:** _____

PREGNANCY & BIRTH
 Total # of Living Children _____ Weight Gain/Loss _____ Mother's Age at birth _____
 Number of years between previous pregnancy and this child _____ Trimester prenatal Care began: 1 2 3
 Prenatal Care Provider _____ Vitamins: Y N Iron Y N
 If child over 5 years: uncomplicated pregnancy, labor, delivery, and nursery course Y N (if yes, proceed to CHILD'S MEDICAL HEALTH)

MATERNAL COMPLICATIONS	MATERNAL SUBSTANCE USE	BIRTH/DELIVERY
<input type="checkbox"/> Dental disease <input type="checkbox"/> Vaginal Bleeding <input type="checkbox"/> Hypertension <input type="checkbox"/> Premature labor <input type="checkbox"/> Flu-like illness <input type="checkbox"/> High temperature <input type="checkbox"/> Kidney/bladder infection <input type="checkbox"/> Anemia <input type="checkbox"/> Injury <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Diabetes <input type="checkbox"/> STDs <input type="checkbox"/> Rh Negative <input type="checkbox"/> Exposure to TB <input type="checkbox"/> Exposure to lead/chemicals	<input type="checkbox"/> OTC meds <input type="checkbox"/> Prescription meds <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Street Drugs <input type="checkbox"/> Caffeine <input type="checkbox"/> Other: _____	Place of birth _____ Birth attendant _____ Hours of labor _____ <input type="checkbox"/> Term <input type="checkbox"/> Premature (weeks) _____ <input type="checkbox"/> More than 2 weeks overdue Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> Forceps Complications <input type="checkbox"/> Breech <input type="checkbox"/> Multiple births <input type="checkbox"/> Other _____

NURSERY COURSE Birth weight _____ Birth length _____ FOC _____
 Difficulty w/ initial breathing Infection Jaundice req. treatment
 Heart murmur Transfusion Seizures
 Age at discharge _____ ICN _____ days
 Newborn screening (date/location) 1) _____ 2) _____

Past medical history: please list all illnesses **Drug Allergies:**
 Asthma Allergies Eczema Ear infections Strep throat Pneumonia
 Developmental delays Seizures Anemia Other(s): _____

Family Medical History:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> HIV individual in household
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> other immunosuppression
<input type="checkbox"/> hypertension	<input type="checkbox"/> Muscle/Bone disease	<input type="checkbox"/> Dental decay
<input type="checkbox"/> Asthma/Allergy	<input type="checkbox"/> Genetic disease	<input type="checkbox"/> Alcohol/drug abuse
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Tobacco use
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Learning disorder
<input type="checkbox"/> Domestic violence	<input type="checkbox"/> Psychiatric disorder	<input type="checkbox"/> Other: _____