CHILDREN'S HEALTH HISTORY FORM

Name_____

Home Phone_____ Birth date_____

Age_____ Gender □ M □ F

Height_____ Weight_____

Address_____

City/State/Zip_____

Parent's Name_____

Parent's Employer_____

Parent's Work Phone_____

Payment □ Cash □ Check □ Credit Card

Credit Cd. # _____exp_____

Health Insurance Co. Name_____

Policy Number_____

Policy Holder's Name_____

Social Security # _____

Describe the purpose of this visit. _____

_____

Is the purpose of this appointment related to
□ sports □ auto □ fall □ home injury
□ chronic discomfort □ other

Explain_____

When did this condition begin?_____

Has this condition
□ gotten worse □ stayed constant □ comes and goes

Does this condition interfere with
□ sleep □ daily routine □ other activities

Explain_____

Has this condition occurred before? □ Yes □ No

Explain_____

Have you seen other doctors for this condition?
□ Yes □ No

Dr.'s Name(s)_____

Type of Treatment_____

Results_____

MOTHER'S PREGNANCY & LABOR

During pregnancy, did the mother:
take any medication? □ No □Yes
Explain_____
smoke or consume alcohol? □ No □Yes
.experience any illness? □ No □ Yes
Explain_____
Approximately how long did labor last?_____ hours
Was labor chemically induced? □ No □ Yes
Was labor doctor assisted? □ No □ Yes
Was a C-Section performed? □ No □ Yes
Were forceps or vacuum extraction used? □ No □ Yes
Did the delivery doctor pull or twist the baby during delivery? □ No □ Yes
Was the delivery premature? □ No □ Yes
If "Yes", at _____ month and _____weight
Check any of the following if the child experienced it immediately after birth.
□ Jaundice □ Respiratory Problems
□ Feeding Problems □ Displaced or Broken Joints
□ Other Condition(s)
Explain_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or had in the past. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis.

□ Vision Problems □ Pink Eye
□ Headaches □ Ear Problems
□ Sleeping Disorders □ Tubes in Ears
□ Irritability □ Attention Problems
□ Skin Problems □ Frequent Colds
□ Allergies □ Colic
□ Breathing Problems □ Digestive Problems
□ Asthma □ Constipation
□ Hyperactivity □ Bed Wetting
□ Other _____
_____
_____