

# Child Medical History (0-10 year olds)

NAME:	DATE OF BIRTH:
	TODAY'S DATE:
MOTHER'S NAME:	If parents divorced/separated, who has custody?
FATHER'S NAME:	
Is your child either: <input type="checkbox"/> Native American or <input type="checkbox"/> Native Alaskan	

## CHILD'S BIRTH HISTORY

Preterm: <input type="checkbox"/> No <input type="checkbox"/> Yes (gestational age: _____ weeks)	Birth weight:
Pregnancy complications?	
Vaginal birth? <input type="checkbox"/> No <input type="checkbox"/> Yes	Delivery complications?
How many days did your child spend in the hospital after birth?	

## PAST MEDICAL HISTORY

Please place a checkmark next to any condition your child has had:

<b>Heart or Blood Vessels</b>		<b>Muscles, Joints and Bones</b>	
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Abnormal heart rhythm	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Other:	<b>Social or Mental Health</b>	
<b>Lungs</b>		<input type="checkbox"/>	Depression
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Attention deficit disorder
<b>Digestion</b>		<input type="checkbox"/>	Learning disorder
<input type="checkbox"/>	Inflammatory bowel disease	<input type="checkbox"/>	Sleep problems
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Behavior problems
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
<b>Kidneys or Bladder</b>		<b>Infectious Diseases</b>	
<input type="checkbox"/>	Frequent bladder infections	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Other:	<input type="checkbox"/>	HIV
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
<b>Metabolism</b>		<b>Skin</b>	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Other:	<b>Other</b>	
<b>Nerves and Brain</b>		<input type="checkbox"/>	
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	
<input type="checkbox"/>	Other:	<input type="checkbox"/>	

Did your child visit the emergency room or need hospitalization in the last year?

Date	Reason

**SURGICAL HISTORY**

Type of Surgery	Year	Surgeon

**FOR GIRLS**

Has your daughter started her periods?  No  Yes: If Yes, when?

Are her periods:  Regular  Irregular  Heavy  Accompanied by severe cramping

**HEALTH MAINTENANCE**

Are your child's immunizations up-to-date?  No  Yes (Please attach immunization records.)

Last well-child exam:

Last dental visit:

Diet:

Infants (check all that apply)  Breastfeeding (how often? \_\_\_\_\_)  Formula  Solids

Children (please describe):

How many times/week does your child exercise?  0  1-2  3-4  5-7

How many minutes does your child exercise each time?  10-15  15-30  30-45  >45 min

Types of activities:

Does your child see an **alternative health-care provider** (chiropractor, naturopath, acupuncturist)?  No  Yes

**ALLERGIES**

Medication or Other Item	Reaction (e.g., rash, swelling, difficulty breathing)

**MEDICATIONS**

Medication (including vitamins, herbs, supplements)	Dose	Frequency	Prescribed by

**FAMILY MEDICAL HISTORY**

Please place a check next to any conditions that an immediate family member has (parents, grandparents, siblings):

	Who
Asthma, allergies	
Cancer (what type? )	
Diabetes	
Heart attack or heart disease	
High blood pressure	
Mental health problems	
Inherited disorders	
Other conditions	

**SOCIAL HISTORY**

School:	Grade:
Any problems at school requiring special attention? <input type="checkbox"/> No <input type="checkbox"/> Yes: If Yes, what:	
Daycare/nanny name:	Phone Number:
Parents are: <input type="checkbox"/> Married/partnered <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Who lives at home with you?	
Name	Relationship Age
TV (hours/day):	Computer/Video games (hours/day):

Please answer the following questions by placing a checkmark under either the “Yes” or “No” column:

	Yes	No
Do you have any concerns about your child’s mental or physical development, behavior or mood?		
Do you have a smoke detector in the home?		
Does your child wear a bike helmet when biking?		
Does your child use a car seat or booster seat?		
Does your child use a seatbelt?		
Are there guns in the home?		
Does your child feel safe in your home and neighborhood?		
Is there any history of abuse in the home? (emotional, sexual, physical)?		
Does anyone smoke in the home?		
Are there any alcohol or street drug problems in the home?		
During the past 2 weeks, has your child felt down, depressed or hopeless?		
During the past month, has your child often felt so anxious that s/he couldn’t stand it?		

We would like to ask a few more questions to better understand your child's health care needs. Please circle the answer that applies to your child.

How do you rate your child's health?	Very unhealthy	Unhealthy	Average health	Healthy	Very healthy
Over the last year, how satisfied have you been with your child's health care?	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
In the past year, how many times has your child been treated in an Emergency Room?	5 or more		2-4	0 or 1	
In the past year, how many times has your child been hospitalized?	3 or more		2	0 or 1	

We would like to know about your experience with past medical care. Thank you so much.

I had one person that I thought of as my child's personal doctor or nurse.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It was easy for my child to get medical care when she/he needed it.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Most of the time, when we visited my child's doctor's office, it was well-organized, efficient, and did not waste our time.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information given to me about my child's health problems was very good.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I am confident that I can manage and control most of my child's health problems.	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

Other comments or suggestions:



**COMMUNITY HEALTH MEDICAL HOME**

**Ballard**

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