SWEDISH

Community Health Medical Home

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: ☐ Native American or ☐ Native Alaskan	

Child's Birth History

Preterm: ☐ No ☐ Yes (gestational age: _____ weeks)	Birth weight:
Pregnancy complications?	
Vaginal birth? ☐ No ☐ 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:

Heart or Blood Vessels	
	Heart murmur
	Abnormal heart rhythm
	Other:
Lungs	
	Asthma
	Other:
Digestion	
	Inflammatory bowel disease
	Other:
Kidneys or Bladder	
	Frequent bladder infections
	Other:
Metabolism	
	Diabetes
	Thyroid problems
	Other:
Nerves and Brain	
	Seizures
	Other:

Muscles, Joints and Bones	
	Arthritis
	Other:
Social or Mental Health	
	Depression
	Anxiety
	Attention deficit disorder
	Learning disorder
	Sleep problems
	Behavior problems
	Other:
Infectious Diseases	
	Hepatitis
	HIV
	Other:
Skin	
	Eczema
	Other:
Other	

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? ☐ No ☐ Yes: If Yes, what:	
Daycare/nanny name:	Phone Number:
Parents are: ☐ Married/partnered ☐ Single ☐ Separated ☐ Divorced ☐ 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

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