Family Care Network
We Take Care

CHILD MEDICAL HISTORY TO AGE 12

Child's Name__________________ Date of Birth __________ Today's Date__________

Parent name __________________ Parent name __________________

MEDICATIONS

List all prescription and over the counter medications that your child is currently taking regularly. Include vitamins, herbs and other supplements and how your child takes them.

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ALLERGIES

Medications your child is allergic to or has reactions to: __________________

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List any non-medication allergies: __________________

IMMUNIZATIONS

Please bring copy of child's immunization record to the visit, or indicate where immunization records are maintained. __________________

TESTS AND EXAMS

Check and indicate date

❑ Physical or Sports exam Date:__________ ❑ Eye exam Date:__________

❑ Well Exam Date:__________ ❑ Other: __________ Date: __________

FOR FEMALES ONLY

Date of last period: __________

Mom's pregnancy and child's birth history:

Mother's pregnancy was ❑ Uncomplicated ❑ Complicated - how? __________

How long was baby in hospital? __________ Birth Weight __________

While pregnant did mother:

❑ Yes ❑ No Use alcohol or drugs

❑ Yes ❑ No Get sick:__________

❑ Yes ❑ No Need any special tests:__________

❑ Yes ❑ No Have problems with delivery

❑ Yes ❑ No Use tobacco

❑ Yes ❑ No Take medication: __________

❑ Yes ❑ No Have problems with labor

❑ Yes ❑ No Have health or adjustment problems after birth for either baby or mother: __________

PERSONAL MEDICAL HISTORY

Check if your child has had:

- ❑ ADD/ADHD/Behavior/Social issues
- ❑ Anemia
- ❑ Asthma
- ❑ Bladder Infections
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Depression
- ❑ Developmental Issues
- ❑ Diabetes
- ❑ Drug or Alcohol Problems
- ❑ Ear Infections - frequent
- ❑ Eating Disorder
- ❑ Headaches
- ❑ Head Injuries
- ❑ Hearing Problems
- ❑ Hives
- ❑ Jaundice
- ❑ Joint Dislocations
- ❑ Kidney Disease
- ❑ Meningitis
- ❑ Physical Abuse
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Seizure or Epilepsy
- ❑ Stomach Ulcer or Reflux
- ❑ Thyroid Problems
- ❑ Vision Problems

Is there anything else about your child's medical history that you would like the doctor to know?______________

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Please list other healthcare providers your child is receiving care from (indicate name & reason):______________

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SURGERIES

Check if child has had: ❑ Tonsillectomy ❑ Adenoidectomy ❑ Appendectomy ❑ Ear Tubes

List any other surgeries:

Type ______________________________ Date__________ Type______________________________ Date__________

Type ______________________________ Date__________ Type______________________________ Date__________

Type ______________________________ Date__________ Type______________________________ Date__________

HOSPITALIZATIONS (Other than for surgery)

Please list:

Date ________________ Reason ____

Date ________________ Reason ____

Date ________________ Reason ____

Date ________________ Reason ____

FAMILY HISTORY

Relationship	Name	Birth Year	Age At Death	Cause Of Death
Father				
Mother				
Brothers & Sisters				

Name ______________________________ Date of Birth __________

FAMILY HISTORY

If there is a family history of any of the following, check the relationship of any that applies:

Condition			
Alcohol or other substance abuse	❑ Mother	❑ Father	❑ Sibling
Asthma	❑ Mother	❑ Father	❑ Sibling
Breast Cancer	❑ Mother	❑ Father	❑ Sibling
Heart Disease	❑ Mother	❑ Father	❑ Sibling
Colon Cancer	❑ Mother	❑ Father	❑ Sibling
Deafness	❑ Mother	❑ Father	❑ Sibling
Depression/Suicide/Mental Illness	❑ Mother	❑ Father	❑ Sibling
Diabetes	❑ Mother	❑ Father	❑ Sibling
Epilepsy/Seizures	❑ Mother	❑ Father	❑ Sibling
Hepatitis (type__________)	❑ Mother	❑ Father	❑ Sibling
Tuberculosis	❑ Mother	❑ Father	❑ Sibling

Other significant family history:____

____

SOCIAL HISTORY

Child is adopted? ❑ Yes ❑ No

Parent Occupation ______________________ Parent Occupation______________________

School_______________________________________ Grade ______________

Name and date of birth for each person *living in child's household*, and their relationship to child: ___________

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Life changes (new siblings, divorce, or death) in the family in the past 12 months: ____________________

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Do you have any religious practices that would affect how we medically care for your child? ❑ Yes ❑ No

RISK FACTORS

❑ Yes ❑ No Passive smoke exposure

❑ Yes ❑ No Uses tobacco, alcohol or street drugs

❑ Yes ❑ No Gets hurt if someone in family gets angry

❑ Yes ❑ No Pets in the home

❑ Yes ❑ No Home was built after 1950

❑ Yes ❑ No Wears helmet for biking, skating, skiing, riding

❑ Yes ❑ No Working smoke detector in the home

❑ Yes ❑ No Gets regular exercise

❑ Yes ❑ No Parents know CPR

❑ Yes ❑ No Hot water heater adjusted to 120 F

❑ Yes ❑ No Firearms in the home are locked and safe

❑ Yes ❑ No Toxins and medications are out of reach

❑ Yes ❑ No Child sees a dentist

❑ Yes ❑ No Always uses car safety restraints

❑ Yes ❑ No Fire extinguisher in the home

❑ Yes ❑ No Eats nutritionally sound diet

❑ Yes ❑ No Uses sunscreen Sun exposure: ❑ Frequently ❑ Occasionally ❑ Rarely ❑ Remote

Amount of milk child drinks daily ______________ Amount of juice/soda each day______________

Hours of screen time each day______________

REVIEW OF SYSTEMS

Circle any/all of the following symptoms that you are **CURRENTLY** concerned about:

GENERAL HEALTH
- ❑ No complaints
- Fever
- Chills
- Sweats
- Loss of appetite
- Fatigue
- Weakness
- Don't feel well
- Weight change
- Wake up tired
- Day fatigue/sleepy
- Snoring
- Sleep problems

EYE
- ❑ No complaints
- Blurring
- Double vision
- Irritation/itching
- Redness
- Discharge
- Vision loss
- Eye pain
- Light hurts eyes

EAR/NOSE/THROAT
- ❑ No complaints
- Earache
- Ear discharge
- Ear ringing/buzzing
- Decreased hearing
- Nasal congestion
- Nasal discharge
- Postnasal drip
- Nosebleeds
- Sore throat
- Hoarseness
- Itching nose/eyes
- Sneezing

CARDIOVASCULAR
- ❑ No complaints
- Chest discomfort
- Pounding/racing heart
- Lightheadedness
- Passing out/fainting
- Shortness of breath with activity
- Shortness of breath lying down
- Sudden waking with shortness of breath
- Swelling in feet/ankles
- Leg pain with exercise

RESPIRATORY
- ❑ No complaints
- Coughing
- Wheezing
- Shortness of breath at rest
- Coughing up phlegm
- Coughing up blood
- Painful breathing

GASTROINTESTINAL
- ❑ No complaints
- Nausea
- Vomiting
- Loss of appetite
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Dark black stools
- Red blood in stools
- Gas/bloating
- Indigestion/heartburn
- Swallowing problems
- Painful swallowing
- Jaundice

GENITAL/URINARY
- ❑ No complaints
- Painful urination
- Blood in the urine
- Frequency
- Genital sores
- Males:
  - Penis discharge
  - Urinating more often
- Females:
  - Urgency
  - Hesitancy
  - Vaginal discharge
  - Missed periods
  - Abnormally heavy periods
  - Abnormal vaginal bleeding
  - Pelvic pain

MUSCULOSKELETAL
- ❑ No complaints
- Neck pain
- Upper back pain
- Lower back pain
- Joint pain
- Joint swelling
- Joint stiffness
- Muscle cramps
- Muscle weakness
- Pain radiating down leg

DERMATOLOGY
- ❑ No complaints
- Rash
- Itching
- Dryness
- Changing lesions
- Non-healing sores

NEUROLOGY
- ❑ No complaints
- Weakness of a limb
- Numbness/tingling in arms/legs
- Seizures
- Tremors
- Dizziness
- Loss of vision
- Balance problems
- Frequent headaches
- Severe headaches
- Difficulty speaking
- Difficulty swallowing
- Clumsiness
- Confusion
- Memory loss

PSYCHIATRIC
- ❑ No complaints
- Feel down, depressed
- Feel overwhelmed
- Little interest/pleasure in doing things
- Anxious or worried
- Excessive sleep
- Inadequate sleep
- Change in appetite
- Difficult to concentrate
- Thoughts of suicide
- Hallucinations
- Fears

ENDOCRINE
- ❑ No complaints
- Get cold easily
- Overheat easily
- Drinking more fluids than usual
- Eating more than usual
- Urinating more than usual
- Unintended weight change

HEMATOLOGY
- ❑ No complaints
- Abnormal bruising
- Bleeding problems
- Bleeding gums
- Frequent nosebleeds
- Enlarged lymph nodes

ALLERGY IMMUNOLOGY
- ❑ No complaints
- Hives
- Allergic rash
- Allergy symptoms
- Seasonal allergies
- Food intolerances
- Animal intolerances
- Recurring/frequent infections

BREAST
- ❑ No complaints
  - Breast lump L or R
  - Breast pain
  - Breast tenderness
  - Breast redness
  - Nipple discharge
  - Bloody nipple discharge
  - Breast enlargement

ANY OTHER HEALTH CONCERNS:

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