

### Health History Form

Site/Home Visitor Name: \_\_\_\_\_

Program Year:  1  2 \_\_\_\_ (Initial)

Child's Name: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_\_  M  F

Authorizing Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Medical Plan: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Dental Plan: \_\_\_\_\_

Insurance:  Geographic Managed Care Medi-Cal  Fee for Service Medi-Cal  Private  None

**Please answer the following questions. If you need more room, use the back of this form. All information is confidential and will be used to better understand and serve the needs of your child.**

**Family Health History**

Has any immediate family member (blood relation) had serious illnesses or abnormalities (e.g. asthma, cancer, convulsions, diabetes, heart disease, inherited disease, mental illness, other)?

No  Yes, please explain: \_\_\_\_\_

Is anyone in the home pregnant?

No  Yes, due date: \_\_\_\_\_

**Pregnancy/Birth History**

Were there complications with pregnancy or birth?

No  Yes

Did mother use any medications, alcohol, street drugs or tobacco during pregnancy?

No  Yes

Was the child born more than 3 weeks early or late?

No  Yes

Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Did the child have any problems at birth or during the first month of life?

No  Yes, please explain: \_\_\_\_\_

**Developmental History**

Please answer Yes or No to the following questions:

Did child sit by 8 months	
Walk by 14 months	
Use simple words by 18 months	
Speak in sentences now	

**Social History**

What words does the child use for?

Bowel movement: \_\_\_\_\_  
Urination: \_\_\_\_\_

Does the child take a nap?

No  Yes, time: \_\_\_\_\_

Have you observed the following in your child? answer Yes or No

Stumbles or drops things often	
Sucks his/her thumb	
Bites his/her nails	

What form of discipline works best with your child? \_\_\_\_\_

List child's fears or worries: \_\_\_\_\_

What activities does child enjoy most? \_\_\_\_\_

With what adults does your child have frequent contact? \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

Does child have an ongoing health problem?  No  Yes: \_\_\_\_\_

Has child had a serious illness, accident, overnight hospitalization or operation?

No  Yes, why: \_\_\_\_\_  
When: \_\_\_\_\_  
Was problem resolved? \_\_\_\_\_

Is child exposed regularly to second-hand smoke?  No  Yes

Does child have any allergies?

No  Yes, allergy: \_\_\_\_\_  
Reaction: \_\_\_\_\_

Please answer Yes or No:

Does child have troubling hearing? \_\_\_\_\_  
Has child had more than 3 ear infections or colds in one year? \_\_\_\_\_  
Does child have tubes in ears? \_\_\_\_\_  
Are you concerned about child's speech? \_\_\_\_\_

Does child have trouble with eyes (squinting, crossed eyes, etc.)? \_\_\_\_\_

Has child been prescribed glasses? \_\_\_\_\_

Does child tire easily? \_\_\_\_\_

Does child have asthma? \_\_\_\_\_

Is child taking vitamins? \_\_\_\_\_

Is child taking iron? \_\_\_\_\_

Prescribed medication, explain: \_\_\_\_\_

**Dental History**

Does child have: (check Yes or No)

Pain/bleeding teeth/gums?  No  Yes

Spots/cavities on teeth?  No  Yes

Does child take fluoride?  No  Yes

Does child drink from a baby bottle?

No  Yes, what: \_\_\_\_\_  
How often: \_\_\_\_\_ When: \_\_\_\_\_

Has child seen a dentist?  No  Yes

Is there anything else you would like us to know about your child? \_\_\_\_\_

Staff Reviewer: \_\_\_\_\_

Date: \_\_\_\_\_