HEALTH HISTORY BIRTH TO 17 YEARS

ADELANTE HEALTHCARE

AA07.PT.FRM

Patient Name: ________________________________ Date of birth: MM/DD/YY ___________________ Date: _______

CHECK CONDITIONS BELOW THAT YOUR CHILD HAS NOW/OR HAS HAD IN THE PAST

- ☐ Alcoholism/drug addiction
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding problem
- ☐ Blood clot in leg or lung
- ☐ Cancer –type:
- ☐ Depression
- ☐ Diabetes – type: _____
- ☐ Epilepsy /Seizures
- ☐ Genital discharge / pain
- ☐ Heart Disease / Attack
- ☐ Hepatitis – type: _____
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Mental health problems
- ☐ Migraines
- ☐ Rheumatic fever
- ☐ Sexually transmitted infection
- ☐ Stomach problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid _________
- ☐ Ulcer
- ☐ Urinary problems / pain

ALLERGIES:

CURRENT MEDICATIONS: *Include prescription, vitamins and over the counter / herbal preparations.*

HAS YOUR CHILD BEEN HOSPITALIZED, HAD SURGERY, SERIOUS INJURIES OR ILLNESSES? IF SO, PLEASE LIST BELOW:

HAS YOUR CHILD BEEN HOSPITALIZED, HAD SURGERY, SERIOUS INJURIES OR ILLNESSES? IF SO, PLEASE LIST BELOW:	YEAR

IMMUNIZATIONS

Are your child's immunizations up to date?
☐ Yes ☐ No ☐ Uncertain

MOTHERS PREGNANCY HISTORY

Pregnancy: ☐ Normal ☐ Abnormal
Labor: ☐ Normal ☐ Abnormal
Delivery: ☐ Normal ☐ C-Section
Feeding: ☐ Breast ☐ Bottle
Comments:_________________________________

FAMILY HISTORY

Check if any family members have had any of the following. Write relationship to you in the space.

- ☐ Alcoholism, drug addiction ☐ Asthma
- ☐ Cancer – type:________
- ☐ Depression /Mental health problems
- ☐ Diabetes-type:_______
- ☐ Epilepsy/Seizures
- ☐ Heart disease
- ☐ Hepatitis-type:________
- ☐ High blood pressure
- ☐ Lung disease (emphysema/TB)
- ☐ Stroke ☐ Thyroid
- ☐ Other_____________________

SOCIAL HISTORY

1. Do you feel the child is physically and emotionally safe in the family and your home? ☐ Yes ☐ No
2. Do you have financial concerns? ☐ Yes ☐ No
3. Does the child have any vision problems? ☐ Yes ☐ No
4. Does the child have any hearing problems? ☐ Yes ☐ No
5. Does the child have any learning problems? ☐ Yes ☐ No
6. Does the child have any emotional problems? ☐ Yes ☐ No
7. Does the child get regular exercise? ☐ Yes ☐ No If yes, activity: ____________How often?_________
8. Does the child use Alcohol? ☐ Yes ☐ No
   If yes, type: ___________ frequency:_______
9. Does the child use Illegal Drugs? ☐ Yes ☐ No
   If yes, type: _________frequency:_______
10. Does the child use Tobacco? ☐ Yes ☐ No
    If yes, type:__________# times per day:______ since:______

PHYSICAL DEVELOPMENT

At What age did your child:
Sit Up:_________ Talk:___________ Walk:______________
Self-Feed:_________
First Menstrual Cycle (if applicable):____________

Signature of Parent or Guardian:____ Date: ________________________________

Provider Review____ Date: ______________________________