Huntington Family Medicine

Children History Form

Name: _____ D.O.B: _____ Today's Date: _____

Birth History for Patient:

Was the pregnancy full term? Y or N
Were there complications with the pregnancy or delivery? Y or N
Did you go home in 24- 48 hours? Y or N
If not, why? _____
How much did the child weigh at birth? _____

Past Medical History: Has the child had any of the following Conditions?

□ Abdominal problems	□Frequent Temper Tantrums	□Pneumonia
□ Any serious injury	□Hay fever/Sinus Problems	□School problems
□ Asthma	□Hearing Problems	□Seasonal allergies
□ Behavior problems	□Heart problems	□Seizures
□ Broken bones	□Joint/bones problems	□Underweight
□ Chronic cough	□Kidney/Bladder infection	□Vision problem
□ Constipation	□Many ear infections	

□ Skills are behind other kids □Other:_____

Any Allergies to Medications? _____
Any Medications/Supplements taken frequently? _____

Social History:

Child has how many sisters? _____ Brothers? _____
Grade in school/Preschool? _____
Usual Grades Received ? _____
Is your child in daycare/ afterschool care? _____
Who lives with the child? _____

Exposures:

Is there a smoker in the home/ at babysitter? Y or N
Do you always use seatbelt or car seat in your vehicle? Y or N

Family History: Has any blood relative of your child had…

□ Alcoholism	□Depression	□Lung disease
□Allergies	□Diabetes	□Mental illness
□Asthma	□Drug addiction	□Seizures
□Bleeding disorder	□ Heart Problem	□Stroke
□Blood clots	□ Heart vessel surgery	□Tuberculosis (TB)
□Cancer	□High blood pressure	□High cholesterol
□Deafness	□ Other: _____	

Parents Name: _____ Signature: _____