

UPDATE TO CHILD'S HEALTH HISTORY

NAME: _____ Age: _____ Today's Date: _____

Any new family health problems?
Any changes at home, school or daycare?
Who lives in your home?

NEW OR CONTINUING PROBLEMS: (circle any that apply)

General: Fevers or chills. Weight change. Appetite change
Eyes: Vision concerns. Eye discharge or discomfort.
Eye care provider and last exam: (Age 3 or older) _____
Ears: Change in hearing or ear pain. Nasal congestion or bleeding.
Mouth: Mouth sores, sore throat, dental problems
Dental provider and last exam: (Age 3 or older) _____
Heart: Chest pain or heart concerns
Lungs: Cough or shortness of breath.
Breasts: Pain, nipple discharge or masses
Bowels: Abdominal pain, change in bowels, bleeding, heartburn, spitting up
Urinary: Urinary problems, menstrual problems
Muscle/bone: Injuries, joint or muscle or back pain
Brain, spine: Speech or developmental concerns; headaches
Skin: Rashes or concerning lesions
Metabolism: Unusual thirst or weight loss.
Emotions: Depression or anxiety; school problems, fears
Allergy: Allergy symptoms

List medications (PRESCRIPTION AND NON-PRESCRIPTION):

Medication allergies:

Is there tobacco use in child's home?

SLEEPING - TYPICAL WAKE AND SLEEP TIMES

DISCIPLINE - HOW IS THIS APPROACHED AT HOME?

FAVORITE ACTIVITIES?

HOW MANY HOURS OF TV PER DAY?

HOW OFTEN IS CAR SEAT OR SEAT BELT USED WHEN RIDING IN A CAR?

DESCRIBE EATING PATTERNS, NUMBER OF MEALS PER DAY, DIETARY PROBLEMS: