

UPDATE TO CHILD'S HEALTH HISTORY

**PARENTS NEED TO BRING IMMUNIZATION RECORDS WITH THEM
TO THIS VISIT!**

NAME: _____
BIRTHDATE: _____ AGE: _____
ANY NEW FAMILY HEALTH PROBLEMS? _____

RECENT SYMPTOMS (CIRCLE ANY THAT APPLY TODAY):

GENERAL: Fever or chills. Weight change. Appetite change
EYES: Vision concerns. Eye discharge or discomfort
EARS: Change in hearing or ear pain. Nasal congestion or bleeding
MOUTH: Mouth sores or sore throat. Dental problems
Dental provider and last exam? (Age >3) _____
CV: Chest pain or heart concerns
RESP: Cough or shortness of breath
BREASTS: Pain, nipple discharge or masses
GI: Abdominal pain, change in bowels, bleeding, heartburn, spitting up
GU: Urinary problems, menstrual problems
MS: Injury to joint or muscle or back pain
NEURO: Speech or developmental concerns. Headaches
SKIN: Rashes or concerning lesions
ENDO: Unusual thirst or weight loss
PSYCH: Depression. Anxiety
ALLERGY: Allergy concerns

MEDICATIONS: (PRESCRIPTION OR NON-PRESCRIPTION): _____

MEDICATION ALLERGIES: _____

TOBACCO USE IN THE HOUSEHOLD: YES NO

BEHAVIOR CONCERNS:

Sleeping: _____
Development: _____
Discipline: _____

FAVORITE ACTIVITIES:

Hours of TV watched per day:
Frequency of child's seat belt/car seat use: 0% 25% 50% 75% 100%
Describe eating patterns, favorite foods, foods avoided, number of times child eats daily:

