UPDATE TO CHILD'S HEALTH HISTORY 0-12

NAME: _____ Age: _____ Appointment Date: _____

Any new family health problems?
Childcare arrangements (i.e. home, daycare, sitter)
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: