ResourceCare
COMMUNITY HEALTH CENTER

HEALTH HISTORY
AGES 3 TO 11 YEARS

If needed, please ask for assistance in completing this form.
Si necesita ayuda para llenar estas formas, por favor de decirnos nosotros le podemos ayuda.

Today's Date: ____________________

PLEASE PRINT CLEARLY

Patient Name: ____________________ Date of Birth: __________ Age: ________

Please take a few minutes to complete this history for your child.

Has your child ever had:	No	Yes	Education Needed	Education Done		Have you or your child's teacher noticed:	No	Yes	Education Needed	Education Done
Repeat ear infections						Physical deformity				
Long-term nasal congestion						Hearing problems				
Teeth/gum problems						Problems seeing				
Repeat tonsillitis						Speech problems				
Bronchitis						Nervous habits				
Asthma or Wheezing						Bed wetting, once trained				
Repeat pneumonia						Temper tantrums				
Heart Problems						Sleep problems				
Stomach problems						Frequent fights				
Urinary infections						School problems				
Broken bones						Poor weight gain				
Surgery										
Diabetes										
Seizures										
Muscle or joint pain										
Positive TB skin test										

If your child is 5 years old or less, please answer the following questions about the mother's pregnancy and the child's birth:

	No	Yes	Explanation if needed
Did mother see the doctor regularly while pregnant?			
Was the mother ill while pregnant?			
Did mother take drugs or alcohol?			
Was the baby born when full-term?			
Was it a normal vaginal delivery?			
Did baby go home with mother?			
Was baby jaundiced or yellow?			
Did baby have feeding problems or colic?			
Does the child have any birth defects?			

How many people live in y our household?____________________ Are you a single parent? ____________________

What is the age of your oldest child? ____________________ What is the age of your youngest child? ____________________

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Has any blood relative of the patient's been diagnosed with any of the following conditions?
(ex: Mother, Father, Maternal Grandmother or Maternal Grandfather, Brother or Sister)

	No	Yes	If yes, please indicate which relative			No	Yes	If yes, please indicate which relative
Diabetes					High Blood Pressure			
Epilepsy					Thyroid Disease			
Migraine					Kidney Disease			
Arthritis					Anemia			
Colon Cancer					Other Cancer			
Heart Attack					Stroke			
Glaucoma					AIDS			
Mental Illness					Tuberculosis			
Asthma					Milk Intolerance			
Female Cancer					Hay fever/Sinus			

Has your child ever been hospitalized or had surgery? _______ Yes _______ No If yes, please explain

Date	Reason

Does your child take any medications regularly? _____ Yes _____ No If yes, please list

Medication	Taken For	Physician Prescribed

Conditions your child has been diagnosed with: ____

____

____

AUTHORIZATION AND RELEASE

I certify to that I have read and understand the above information to the best of my knowledge.
The above questions have been accurately answered.

____ ____ ______________________
Patient/Guardian Signature Printed Name Date