

Child Health History

Department of State Health Services Child Health Record Preventive Health Visit

Pregnancy and Birth

G ____ P ____ AB ____
Total number of living children ____ Weight gain/loss ____
Mother's age at birth ____
Number of years between previous pregnancy and this child ____
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider ____
Vitamins: ____Y ____N Iron: ____Y ____N
If child over 5 years: uncomplicated pregnancy, labor, delivery and nursery course: ____Y ____N*
**If yes, proceed with "Child's Medical History."*

Maternal Complications

____ Vaginal bleeding ____ Flu-like illness or high temp.
____ Anemia ____ Kidney or bladder infection
____ Hypertension ____ STDs
____ Rh negative ____ Hepatitis (A, B, or C)
____ Diabetes ____ Exposure to TB
____ Premature labor ____ Exposure to lead/chemicals
____ Injury/hospitalization/surgery ____ Dental disease

Maternal Substance Use

____ OTC meds ____
____ Prescription meds ____
____ Tobacco ____
____ Alcohol ____
____ Street drugs ____
____ Caffeine ____

Family Medical History

Abbreviations for relatives listed below.

M - Mother	MGM - Maternal Grandmother	PGM - Paternal Grandmother
F - Father	MGF - Maternal Grandfather	PGF - Paternal Grandfather
S - Sibling	MA - Maternal Aunt	PA - Paternal Aunt
	MU - Maternal Uncle	PU - Paternal Uncle

____ Anemia/blood disorder Y N HIV + individual in household
____ Heart disease before age 50 **(do not identify)**
____ Cholesterol req. treatment ____ Other immunosuppression
____ Hypertension/stroke ____ Dental decay
____ Asthma/allergy ____ Alcohol/drug abuse
____ Cancer ____ Tobacco use
____ Diabetes ____ Learning disorder
____ Epilepsy/seizures ____ Mental retardation
____ Kidney problems ____ Psychiatric disorder
____ Muscle/bone disease ____ Physical/sexual/emotional abuse
____ Genetic disease or major birth defects ____ Domestic violence
____ Childhood hearing impairment ____ Other
____ Tuberculosis

Explanation of positive history:

Client Information

Name: _____
DOB: ____ / ____ / ____ Age: ____ Sex: ____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Birth/Delivery

Place of birth _____
Birth attendant _____
Hours of labor _____

____ Term **Complications:**
____ Premature (Weeks) ____ ____ Breech
____ More than 2 weeks overdue ____ Multiple birth
Type of delivery: ____ Other

____ Vaginal
____ C-Section
____ Forceps

Explanation/Other:

Nursery Course

Birth Weight ____ Birth Length ____ FOC ____

____ Difficulty with initial breathing ____ Transfusion
____ Heart murmur ____ Jaundice req. treatment
____ Infection ____ Seizures

Age at discharge: ____ ICN ____ days

Newborn blood screening (date/location):

1. _____
2. _____

Newborn hearing test (in hospital):

 ____ Normal ____ Abnormal

Type of test: ____ ABR ____ OAE ____ Unknown

Referral made: ____ Y ____ N

Comments:

Child's Medical History

Immunizations current: ____ Y ____ N ____ Record unavailable
Dental care/sealants current: ____ Y ____ N

____ Trauma/injuries	____ Vision problems
____ Hospitalizations	____ Hearing problems
____ Surgery	____ Seizures
____ Medications	____ Environmental toxin exposure (lead, etc.)
____ Anemia	____ Allergies
____ Early childhood caries	____ Asthma
____ Hepatitis	____ Eczema
____ Strep throat	____ Substance use (alcohol, drug, tobacco)
____ Ear infections	____ Other
____ Bladder/kidney infections	
____ Pneumonia	
____ Developmental delays	

Explanation:

Date: _____ Signature/Title: _____ Signature/Title _____

