RIO FAMILY MEDICINE

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HEALTH HISTORY--CHILD

Date:

Name: _____ Birth Date: _____ Age:_____

Social Security Number: Phone Day: Cell: Home:

PAST MEDICAL HISTORY: Has your child ever had any of the following illnesses?
Please circle and state **year of onset**

ADD or ADHD	Diabetes	Seizures	
Allergy/hayfever	Heart problems	Urinary infections	
Anemia	High cholesterol	Venereal Disease	
Asthma	High blood pressure	Other:	
Birth Defects	Hives/eczema		
Birth Complications	Kidney disease		
Colitis	Migraines	Other:	
Depression	Pneumonia		
Delays in Development	Premature Birth		

HOSPITALIZATIONS: Has your child ever been hospitalized for operations, illness, or injury?

Reason/Year	Reason/Year

MEDICATIONS: List current medications and dosage, including over the counter medications and supplements:

Medication	Dose	Frequency	Medication	Dose	Frequency

ALLERGIES: Allergy to any drug_____

X-Ray Dye_____ Food _____

IMMUNIZATIONS :

Is your child up to date?	Yes	No
Do you have the shot record?	Yes	No
Any severe reactions to shots?	Yes	No
Where were most recent immunizations given?		

SCREENING EXAMS: Has your child had screening exams?

Anemia/iron	Cholesterol	Lead

SOCIAL HISTORY:

Does anyone in the house smoke? Yes _____ No _____
Was your house built before 1950? Yes _____ No _____
If your house was built before 1978, do you have chipped or peeling paint? Yes _____ No _____

Patient Name:_____ Date:_____

Does your child live with you all the time?_____ Who else lives with you? _____
Does your child have problems in school?_____
Does your child have trouble making and keeping friends? _____
Are the child's parents married? Yes _____ No _____

FAMILY HISTORY: Has any member of your child's family (parents, brothers, sisters,) had any of the following?
Please state who in the family. F=Father M=Mother S=Sibling

Alcoholism	F	M	S	Cancer – Breast		M	S
Asthma	F	M	S	Cancer – Colon		M	S
Depression	F	M	S	Cancer – Ovarian	F	M	S
Diabetes	F	M	S	Cancer – Other	F	M	S
Heart disease	F	M	S	Hives/Eczema	F	M	S
High blood pressure	F	M	S	Epilepsy	F	M	S
High cholesterol	F	M	S	Other	F	M	S
Osteoporosis	F	M	S		F	M	S
Stroke	F	M	S		F	M	S

Please mark below:	IF LIVING		IF DECEASED	
	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER 1				
BROTHER 2				
SISTER 1				
SISTER 2				

TEENS COMPLETE THE FOLLOWING:
Do you smoke? Yes No Number per day?_____
Do you drink alcoholic beverages? Yes No How much? _____
(If you use illicit drugs, please speak to us in confidence.)
Do you exercise? Yes No How often? _____
How would you describe your weight? Underweight _____ About Right _____ Overweight_____
Do you have a friend you can talk to about almost everything? _____
What school do you attend? _____
What is your grade average, most recently? _____
Do you do any organized activities outside the classroom?_____
Hobbies/Social activities:_____
What percentage of the time do you wear a seatbelt? _____
Do you use a cell phone while driving? _____
Is there anything you would like to talk to the doctor about?_____

For Girls Only: Do you have periods? _____ Are they regular? _____
Do you have bad PMS? _____