Rancho Paseo Medical Group **CHILD, Health History Form**

Child's Last Name:_____
Child's First Name: _____
Date: _____ Phone: _____

PERSONAL HISTORY

Date of Birth: _____ Birthplace: _____

Is the Child Yours by: ☐*BIRTH* ☐*ADOPTION* ☐*STEP CHILD* ☐*OTHER*

Any Medical Problems during pregnancy: ☐*NONE* If yes, specify:

_____

Delivery by: ☐*Vaginal Delivery* ☐*Caesarean (why):*_____ _____

Was your child breastfed? ☐*No* ☐*Yes (how long):* _____

Any feeding or dietary problems? ☐*NO* ☐*YES*

*(specify):*_____

Ethnic Background: ☐*American Indian* ☐*Asian* ☐*African American*

☐*Filipino* ☐*Caucasion* ☐*Pacific Islander* ☐*Other:* _____

Recreation / Play / Exercise:_____

Sleep: Avg Hrs per night: _____

Naps (number & length): _____

ALLERGIES TO MEDICATIONS ☐*NO KNOWN ALLERGIES*

Substance / Medication	Reaction

HOSPITALIZATIONS & SURGERIES

Year	Hospital	Reason for Hospitalization or Surgery

PLEASE BRING CHILD'S IMMUNIZATION RECORD TO EVERY APPOINTMENT

Has your child had: ☐*Chickenpox* ☐*Measles* ☐*Mumps*

☐*Rubella* ☐*Meningitis* ☐*Tuberculosis (TB)*

Date of Last :

Tetanus Shot: _____ Flu Shot:_____

Gardasil: _____

List Over-the-Counter Medications:

_____ _____

_____ _____

SPIRITUAL ASSESSMENT (optional)

Do you believe in God or a higher power? ☐*YES* ☐*NO*

Would you like to speak with our Chaplain about spiritual matters or grief counseling? ☐*YES* ☐ *NO*

Would you like us to pray for: ☐*You* ☐*Your Family* ☐*Your Health*

Other: _____

☐*YES – during office visit* ☐*YES – while I'm not present.* ☐*NO - Not at this time*

FAMILY HEALTH HISTORY

Check (√) if the child or his/her blood relatives have or Have had any of the following:

Disease	Child	Family	Relation to
Alcohol / Drug dependency			
Asthma/ Chronic Lung Disease			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney disease			
Mental illness or Depression			
Migraines			
Peptic Ulcer			
Seizures			
Stroke			
Thyroid trouble			
Tuberculosis			
Other			