BELLINGHAM
NATURAL FAMILY MEDICINE

CHILD HEALTH HISTORY

To help us meet your healthcare needs, please fill out this form completely in ink. This is a confidential record of your child's health history.

Today's date: _____
Child's name: (Last, First, M.I.): _____ Date of birth _____ Age _____
Parents' names (Last, First M.I.): _____ Phone: _____
_____ Phone: _____
What is your goal for your child's visit? (If well child exam, please state): _____
_____
Are there any specific conditions that you are concerned about? _____
_____
What have you, the parent, already done to help your child be healthier? _____
_____
Name of primary care doctor: _____
Serious illness, trauma, surgery or hospitalization that your child has experienced: _____
_____

FAMILY BACKGROUND:
Who does your child live with? _____
Are parents divorced?____If so, what type of arrangements (visitation, etc.) are made for the other parent?
_____
_____

FAMILY MEDICAL HISTORY:
Please mark relationship of anyone in your family that has had the following conditions: (M = mother, F = father, S = sister, B = brother, A = aunt, U = uncle, MM or FM = mother or father's mother, MF or FF = mother or father's father, MGM or FGM = mother or father's grandmother, MGF or FGF = mother or father's grandfather).

High blood pressure	_____	Heart disease	_____	Stroke	_____
Bleeding tendency	_____	Epilepsy	_____	Allergies	_____
Drug/alcohol problem	_____	Cancer	_____	Asthma	_____
Mental Illness	_____	Ulcer	_____	Obesity	_____
Migraine headaches	_____	Gout	_____	Depression	_____
Thyroid disease	_____	Kidney disease	_____	Other:_____	
High cholesterol	_____	Diabetes	_____		

Food intolerance and reactions they cause:_____

BIRTH HISTORY:
1. Did mother receive prenatal care?_____Take prenatal vitamins?_____
2. State of mother's health during pregnancy_____
3. Did mother smoke cigarettes?_____Drink alcohol?_____Take drugs?_____
4. What type of birth?_____How long was labor?_____
5. Carried to term?_____If no, how premature?_____
6. Birth weight? _____ Birth length? _____ Apgar scores_____
7. Any complications of labor or delivery?_____

Child's name: _____

HEALTH HISTORY: How often does your child experience:

Colds/runny nose	_____	Sore throats	_____	Diarrhea	_____	Earaches	_____
Coughs	_____	Constipation	_____	Headaches	_____	Tummy aches	_____
Diaper rash	_____	Other rashes	_____	Eczema	_____	Trouble sleeping	_____

Others_____

Has your child been immunized? Update: DTaP_____Polio_____HIB_____Hep B_____MMR_____
PCV_____Chickenpox_____Rota_____

What medications has your child been on? (Include details: How often, how long) _____
_____
_____

ENVIRONMENTAL HISTORY:
Do you have indoor pets?_____If so, what kind?_____
What type of dwelling do you live in?_____How old?_____
Any remodeling recently?_____Has your child been exposed to any chemicals or toxins?_____
Do you heat with a wood stove?_____Does anyone in the family smoke cigarettes?_____

DIET:
1. What does your child typically eat?
   Breakfast:_____
   Snack:_____
   Lunch:_____
   Snack:_____
   Dinner:_____
   Snack:_____
   What does she/he drink and how much?_____

2. What foods does your child enjoy?_____
   Dislike?_____

3. What supplements does your child take and how often?_____
   _____

STRESSES:
Has your child experienced many stresses in his/her lifetime?_____What kind?_____
_____

SLEEP:
How much sleep does your child get?_____From:_____ p.m. to _____ a.m.

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary health care services my child may need.

X_____ _____
Signature of patient's parent Date