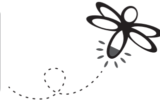
Family Health History



Biological Family History

Mother's and Father's Health History

Diabetes	❏ Mother	❏ Father	
High Blood Pressure	❏ Mother	❏ Father	
Smoker	❏ Mother	❏ Father	
Kidney Problems	❏ Mother	❏ Father	
Asthma	❏ Mother	❏ Father	
Epilepsy, Seizures	❏ Mother	❏ Father	
Birth Defects*	❏ Mother	❏ Father	
Deafness	❏ Mother	❏ Father	
Death under 50 years of age	❏ Mother	❏ Father	
Other*	❏ Mother	❏ Father	
DES Use	❏ Mother	❏ Father	
Menstrual Problems*	❏ Mother	❏ Father	
Heart Attack under 60 years of age	❏ Mother	❏ Father	
Stroke	❏ Mother	❏ Father	
Stomach/Intestinal	❏ Mother	❏ Father	
Intellectual Disability	❏ Mother	❏ Father	
Blood Disease	❏ Anemia	❏ Sickle Cell	❏ Other*
Allergies	❏ Mother	❏ Father	
Bone/Joint Problems	❏ Mother	❏ Father	
High Cholesterol	❏ Mother	❏ Father	
Cancer (Type__________________)	❏ Mother	❏ Father	
Urinary Problems	❏ Mother	❏ Father	
Muscle/Nerve Disease	❏ Mother	❏ Father	

*Please explain:____

____

Family Health History

Is there anyone in the family with a similar disability or chronic illness as your child?

❏ Yes ❏ No

If yes, who/what: ____

____

Is there anyone in the family with:			Relationship to child
Genetic conditions	❏ Yes	❏ No	________________
Heart problems	❏ Yes	❏ No	________________
Developmental disabilities	❏ Yes	❏ No	________________
Seizure disorder	❏ Yes	❏ No	________________
Cerebral Palsy	❏ Yes	❏ No	________________
Diabetes	❏ Yes	❏ No	________________
Blood disorder	❏ Yes	❏ No	________________
Cancer	❏ Yes	❏ No	________________
Vision and/or hearing impairment	❏ Yes	❏ No	________________
Metabolic or nutritional disorder	❏ Yes	❏ No	________________
Cleft Palate	❏ Yes	❏ No	________________
Other ________________________	❏ Yes	❏ No	________________

Has anyone in the family had genetic testing or counseling?

❏ Yes ❏ No ❏ Don't know If yes, please describe:____________________________

____

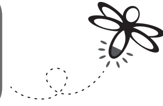
Are there any other family health information that might be related to your child's special health needs? ____

____

Child's Name ______________________ **Date of Birth** / /

Date Last Revised: ____

Birth History



Child's Name ______________________________

Date of Birth ____/_____/_____ Birthweight ________ Length ________

Birth Order (1st, 2nd, etc.) _______________

Obstetrician ______________________________

Address ___________________________City_______________State_____ Zip ________

Phone _________________ Cell _________________ Email _______________________

Hospital where child was born ______________________________

Address ___________________________City_______________State_____ Zip ________

Phone ______________________________

Name of child's primary doctor ______________________________

Address ___________________________City_______________State_____ Zip ________

Phone ______________________________

Notes

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How many months were you pregnant when you first saw a doctor? _______________

How many times did you visit the doctor during your pregnancy? __________________

Drugs/medications taken during pregnancy: ______________________________

____

Any illnesses or problems during the pregnancy?

❏ Yes ❏ No If yes, please describe:______________________________

____

Was the baby full-term (37 weeks or more)?

❏ Yes ❏ No If no, number of weeks of gestation? _______________

Length of labor _____________

Delivery method: ❏ Normal ❏ Caesarean ❏ Breech ❏ Precipitate (sudden)

Child's Apgar scores at 1 minute_________________; at 5 minutes________________

Child's condition at birth ______________________________

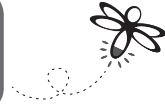
____

Child was fed: ❏ breast milk ❏ formula (brand_____________________)

Child's age at hospital discharge ________

Child was in the hospital from ____/_____/_____ to ____/_____/_____

Eating History



When your child came home from the hospital, what type of food did he/she eat:

❏ breast milk ❏ regular formula ❏ special formula ❏ other____________________

Changes in feeding

Breast to bottle child's age __________ why change? ________________________

____

Formula change child's age__________why change and changed to what?________

____

Bottle to cup child's age __________ why change? ___________________________

____

Started solid food child's age __________

Food allergies ____

____

Textures ____

____

NPO & Tube Feedings ____

____

Other changes ____

____

____

How long does it take your child to finish a bottle or eat a meal? _______________

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Are there any problems (vomiting, choking, swallowing, refusing to eat, diarrhea, etc.)?

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Notes

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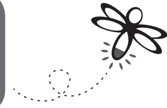
Child's Name ____________________ **Date of Birth** / /

Date Last Revised: ____________________

Milestones



Developmental Milestones

This list can be used as a guide and for any questions you may have for your child's physician.

	Age	Notes/Questions
Smiled	_____	________________________________
Laughed out loud	_____	________________________________
Held up head	_____	________________________________
Rolled over	_____	________________________________
Sat up	_____	________________________________
Sat alone	_____	________________________________
Got first tooth	_____	________________________________
Started solid food	_____	________________________________
Drank from glass/cup	_____	________________________________
Used utensils	_____	________________________________
Crawled	_____	________________________________
Spoke first word	_____	________________________________
Waved "bye"	_____	________________________________
Walked	_____	________________________________
Walked alone	_____	________________________________
Spoke first sentence	_____	________________________________
Toilet		
Indicated need	_____	________________________________
Toilet trained – bladder	_____	________________________________
Toilet trained – bowel	_____	________________________________
Dressed self	_____	________________________________
Washed self	_____	________________________________
Other _______________	_____	________________________________
Other _______________	_____	________________________________

Notes

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Child's Name ____________ **Date of Birth** / /

Date Last Revised: ______________________

Dental History

Dentist ______________________________

Address ____________ City ________ State _____ Zip ______

Phone ________ Cell ________ Email ____________

Dental Specialist ______________________________

Address ____________ City ________ State _____ Zip ______

Phone ________ Cell ________ Email ____________

All children should have routine dental care; such care may be even more important when your child has a special health care need. Consult with your family dentist or your child's medical specialist to determine if specialized dental services are required.

Before the dental exam, the dentist should have information about your child's medical condition and current care. Discuss any precautions recommended by your child's medical specialist as well as provide a list of current medications your child is taking.

❏ Dentist has been informed of medical condition, medications, allergies (latex or other) and medical specialist's recommendations.

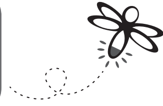
Notes

Date	Appointment Time	What Occurred at Appointment	Follow-up Information (Sedation provided/Antibiotics Given/Needed)

Child's Name ____________ **Date of Birth** / /

Date Last Revised: ____________

Test Results



Other

❏ Blood ❏ X-ray ❏ CT ❏ MRI ❏ Other____________ Date Performed _____________
Doctor who ordered test ______________________________
Phone ______________________________
Description ______________________________
Results ______________________________
Location of Test Record ______________________________
Phone ______________________________
Comments ______________________________
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____

❏ Blood ❏ X-ray ❏ CT ❏ MRI ❏ Other____________ Date Performed _____________
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Phone ______________________________
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Results ______________________________
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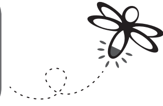
Child's Name ______________ **Date of Birth** / /

Date Last Revised: ______________________________

Test Results



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Doctor who ordered test ____

Phone ____

Description ____

Results ____

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Phone ____

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____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Phone ____

Comments ____

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❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Phone ____

Comments ____

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❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

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Comments ____

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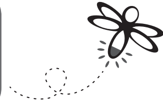
Child's Name ____________ **Date of Birth** / /

Date Last Revised: ______________________________

Test Results



Other

❏ Blood ❏ X-ray ❏ CT ❏ MRI ❏ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

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❏ Blood ❏ X-ray ❏ CT ❏ MRI ❏ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Phone ____

Comments ____

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❏ Blood ❏ X-ray ❏ CT ❏ MRI ❏ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Phone ____

Comments ____

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❏ Blood ❏ X-ray ❏ CT ❏ MRI ❏ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Phone ____

Comments ____

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Child's Name ____________ **Date of Birth** / /

Date Last Revised: ____________________

Illness/Infection/Injury History

Illness/Infection/Injury	Date	Duration	Drugs Taken	Physician	Location	Treatment

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Child's Name ____________ **Date of Birth** / /

Date Last Revised: ____________

Diagnoses

Diagnosis	Abbreviation	Also Called	Physician Who Diagnosed	Physician's Specialty	Date of Diagnosis

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Child's Name ______ **Date of Birth** / /

Date Last Revised: ______

Immunization and Allergy Record

	Date	Physician	Reaction	Date	Physician	Reaction
Hepatitis B						
Diptheria/Tetanus (DT)						
Diptheria/Pertussis/Tetanus (DPT)						
Tetanus						
Polio						
Influenza Type B						
Measles/Mumps/Rubella (MMR)						
Measles (Rubeola)						
Mumps						
Rubella (3-day Measles)						
Varicella Zoster						
Meningococcal Conjugate Vaccine						
Other:						
TB Skin Tests (PPD)						
Lead Screening						
Other:						

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Child's Name ______________ **Date of Birth** / /

Date Last Revised: ______________