Family Health History



Family Health History

Biological Family History

Mother's and Father's Health His	tory			Is there anyone in the family with a	similar di	sability or	chronic illness as your child?
Diabetes	■ Mother	□ Father		□ Yes □ No			
High Blood Pressure	■ Mother	□ Father		If yes, who/what:			
Smoker	■ Mother	□ Father					
Kidney Problems	■ Mother	☐ Father					
Asthma	■ Mother	☐ Father		Is there anyone in the family with:			Relationship to child
Epilepsy, Seizures	■ Mother	☐ Father		Genetic conditions	☐ Yes	☐ No	
Birth Defects*	■ Mother	□ Father		Heart problems	Yes	☐ No	
Deafness	■ Mother	□ Father		Developmental disabilities	Yes	☐ No	
Death under 50 years of age	■ Mother	☐ Father		Seizure disorder	☐ Yes	☐ No	
Other*	■ Mother	☐ Father		Cerebral Palsy	☐ Yes	☐ No	
DES Use	■ Mother	□ Father		Diabetes	Yes	☐ No	
Menstrual Problems*	■ Mother	□ Father		Blood disorder	Yes	☐ No	
Heart Attack under 60 years of age	■ Mother	□ Father		Cancer	Yes	☐ No	
Stroke	■ Mother	☐ Father		Vision and/or hearing impairment	☐ Yes	☐ No	
Stomach/Intestinal	■ Mother	☐ Father		Metabolic or nutritional disorder	☐ Yes	☐ No	
Intellectual Disability	■ Mother	☐ Father		Cleft Palate	☐ Yes	☐ No	
Blood Disease	□ Anemia	☐ Sickle Cell	☐ Other*	Other	☐ Yes	☐ No	
Allergies	■ Mother	☐ Father					
Bone/Joint Problems	■ Mother	☐ Father		Has anyone in the family had genet	ic testing	or counse	eling?
High Cholesterol	■ Mother	☐ Father		☐ Yes ☐ No ☐ Don't know If ye	s, please	describe:	
Cancer (Type)	■ Mother	☐ Father					
Urinary Problems	■ Mother	☐ Father					
Muscle/Nerve Disease	■ Mother	☐ Father		Are there any other family health in	formation	that migh	t be related to your child's
				special health needs?			
*Please explain:							
pediatric palliative care coal	lition <u>°</u>			Child's Name			Date of Birth

Birth History

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Child's Name				How many months were you pregnant when you first saw a doctor?
	/ Birthweight		······································	How many months were you pregnant when you hist saw a doctor:
	g, 2nd, etc.)			How many times did you visit the doctor during your pregnancy?
,	, ,			
Obstetrician				Drugs/medications taken during pregnancy:
Address	City	State	_ Zip	
Phone	Cell E	mail		
				Any illnesses or problems during the pregnancy?
Hospital where c	hild was born			☐ Yes ☐ No If yes, please describe:
Address	City	State	_ Zip	
Phone				
				Was the baby full-term (37 weeks or more)?
=	orimary doctor			☐ Yes ☐ No If no, number of weeks of gestation?
Address	City	State	_ Zip	Length of labor
Phone				
Notes				Delivery method: ☐ Normal ☐ Caesarean ☐ Breech ☐ Precipitate (sudden)
Notes)				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/

Child's Name

Date Last Revised:

Date of Birth

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	How long does it take your child to finish a bottle or eat a meal?
Changes in feeding Breast to bottle child's age why change?	Are there any problems (vomiting, choking, swallowing, refusing to eat, diarrhea, etc.)?
Formula change child's agewhy change and changed to what?	
Bottle to cup child's age why change?	Notes
Started solid food child's age	
Food allergies	
Textures	
NPO & Tube Feedings	
Other changes	

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Child's Name

Date of Birth



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		
0.11		

Notes

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	Lait Lua	
O Concentro		

Child's Name

Date of Birth

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Dental History



Notes

Dentist						
Address		City		State	Zip	
Phone			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.

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

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Child's Name

Date of Birth

Date	Last	Roy	ricor	1-

Test Results



W . T 1	_

□ Blood □ X-ray □ CT □ MRI □ Other	Date Performed	💶 🗀 Blood 🗅 X-ray 🗅 CT 🗅 MRI 🗅 Other	Date Performed	
Doctor who ordered test		Doctor who ordered test		
Phone		Phone		
Description				
Results				
Location of Test Record				
Phone		Phone		
Comments		Comments		
□ Blood □ X-ray □ CT □ MRI □ Other	Date Performed	□ Blood □ X-ray □ CT □ MRI □ Other	Date Performed	
Doctor who ordered test				
Phone				
Description				
Results				
Location of Test Record				
Phone		Phone		
Comments		Comments		

Test Results



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□ Blood □ X-ray □ CT □ MRI □ Other	Date Performed	💶 🗀 Blood 🗅 X-ray 🗅 CT 🗅 MRI 🗅 Other	Date Performed			
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Results						
Location of Test Record						
Phone		Phone	Phone			
Comments		Comments				

Test Results



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□ Blood □ X-ray □ CT □ MRI □ Other	Date Performed	💶 🗀 Blood 🗅 X-ray 🗅 CT 🗅 MRI 🗅 Other	Date Performed			
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Doctor who ordered test						
Phone						
Description						
Results						
Location of Test Record						
Phone		Phone	Phone			
Comments		Comments				

Illness/Infection/Injury History



Illness/Infection/Injury	Date	Duration	Drugs Taken	Physician	Location	Treatment
	-					
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Child's Name

Date of Birth



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

pediatric palliative care coalition°	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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