Salmon Falls
family healthcare

www.SalmonFallsMD.com

Child Health History Form

Child Name:_____ **DOB:**_____/_____/_____ **Gender:** ☐ Male ☐ Female

Reason for today's visit:_____

BIRTH HISTORY

Age of mother at birth:_____ Birth Weight:_____ Type of delivery:_____

Problems/medications during pregnancy:_____

Condition of baby at birth:_____

MEDICAL HISTORY *(Please list any medical history and if possible the age for each)*

Chronic illnesses:_____

_____

Daily Medication:_____

_____

Hospitalizations:_____

_____

Surgeries:_____

_____

Additional Injuries requiring medical treatment:_____

ALLERGY HISTORY

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, nausea, respiratory, shock, etc.)

FAMILY HISTORY *(Please check any medical conditions that are present in your family members. If applicable, please list family member beside condition (Mom, Dad, Sibling, Maternal grandparent, Paternal grandparent, Great grandparent, etc.)*

☐ Asthma:_____ ☐ Diabetes:_____

☐ Heart Disease:_____ ☐ Seizures:_____

☐ Thyroid problems:_____ ☐ High blood pressure:_____

☐ Obesity:_____ ☐ Mental illness:_____

☐ High cholesterol:_____ ☐ Cancer (specify):_____

☐ Genetic disorders:_____ ☐ Kidney/disorders:_____

☐ Bowel problems:_____ ☐ ADHD:_____

☐ Learning Disability:_____ ☐ Other (please list):_____

SOCIAL HISTORY

Siblings: ☐ Yes ☐ No Siblings Names & Date of Birth:_____

_____

_____

If parents live separately, where is the child's primary residence?:_____

Who lives at home?:_____

Does your child use a car seat?	☐ Yes	☐ No
Does your child use seatbelts?	☐ Yes	☐ No
Do you wear a seatbelt?	☐ Yes	☐ No
Does your child wear a helmet?	☐ Yes	☐ No
Are there any guns in the house?	☐ Yes	☐ No
If yes, are they locked up?	☐ Yes	☐ No
Do you smoke cigarettes?	☐ Yes	☐ No
Do you put sunscreen on your child?	☐ Yes	☐ No
Do you use sunscreen?	☐ Yes	☐ No

Check all activities that apply for child, and how many hours per day?

☐ Watch TV:_____ ☐ Play Video Games:_____

☐ Use Computer:_____ ☐ Exercise/Sports/Outside Play:_____

How often do you eat at fast food restaurants?_____

Name & Relationship of Person Completing Form:_____

Signature:_____ Date:_____

Witness:_____ Date:_____