EPSDT/HealthCheck Health History Form 7-20 Years

Patient Name: _____ **Date of Birth:** _____ **Race/Ethnicity:** _____

Your Name: _____ **Relationship to Child:** _____ **Child's Age:** _____

Child's Health History

Childhood

Has your child ever been treated for or diagnosed with:

- ☐ Asthma or wheezing _____
- ☐ Pneumonia _____
- ☐ Lung problems _____
- ☐ Heart murmur _____
- ☐ Anemia _____
- ☐ Recurrent ear infections _____
- ☐ Hearing problems _____
- ☐ Vision or eye problems _____
- ☐ Urinary tract infections _____
- ☐ Stomach or digestive problems _____
- ☐ Seasonal allergies or eczema _____
- ☐ Seizures _____
- ☐ Broken bone(s) _____
- ☐ Learning disability _____

_____

- ☐ Depression/anxiety _____
- ☐ ADD/ADHD _____
- ☐ Other chronic medical problems: _____

_____

Has your child ever been hospitalized?

☐ No ☐ Yes Why? _____

Previous surgeries: _____

Please list any specialists, including mental/behavioral health providers, your child is currently seeing and reason: _____

_____

_____

Developmental/Behavior

Do you have concerns about any of the following:

- ☐ Problems with sleeping or nightmares
- ☐ The way your child uses his/her arms, fingers or legs
- ☐ Speech problems
- ☐ Bad temper/breath holding/jealousy
- ☐ Nail biting/thumb sucking
- ☐ Bedwetting (after 6 years)
- ☐ Vision (Are you concerned about your child's vision?)
- ☐ Hearing (Are you concerned about your child's hearing?)

Does your child have problems with:

- ☐ School attendance
- ☐ Getting along with other children including siblings
- ☐ Getting along with parents or other adults
- ☐ Threaten to harm self, others or animals
- ☐ Sexual acting out
- ☐ Destroying property
- ☐ Drug use, alcohol use, smoking, e-cigarettes and/or vaping

Puberty

Concerns about:

- ☐ Body changes
- ☐ Sexual activity
- ☐ Sexually transmitted infection ***(i.e.,Hepatitis B, Hepatitis C, HIV, etc.)***
- ☐ Discharge: vaginal or penis
- ☐ Contraception

For Girls:

Age of first menstrual period? _____

Child's Health History

Medications

Current medications and dose: _____

_____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

_____

Nutrition

☐ Has your child had any dietary problems? _____

_____

- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Food allergies: _____

Dental

- ☐ Problems with teeth or gums
- ☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: _____

Why did he/she see the dentist? _____

Sudden Cardiac Arrest (11 -20 years)

- ☐ Fainted, passed out or had an unexplained seizure suddenly and without warning
- ☐ Experienced exercise-related chest pain or shortness of breath

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Do any household members smoke/use tobacco products/e-cigarettes/ vaping? ☐ Yes ☐ No

TV hours per day _____

Internet/video games hours per day _____

Cell phone/social media hours per day _____

Is violence at home a concern? ☐ Yes ☐ No

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Diagnosed Mental Condition	☐	☐	☐	☐
Drug and/or alchol use	☐	☐	☐	☐
Unexpected Sudden Death	☐	☐	☐	☐
Pacemaker/Imp. Defibrillator	☐	☐	☐	☐

Other _____

Other Concerns:_____

Reviewed by: _____

Date: _____