EPSDT/HealthCheck Health History Form 0-6 Years

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Your Name: _____ **Relationship to child:** _____

Pregnancy and Birth
Medical problems during pregnancy? _____
_____
In utero drug exposure? _____
Where was the child born? _____
Delivered by: ☐ Vaginal ☐ C-section
Why C-section? _____
Birth Weight: _____ Birth Length: _____
☐ Full Term (≥ 37 weeks gestation) ☐ Preterm (≤ 36 weeks gestation)
☐ NICU stay: _____ weeks
Other problems in the newborn period? _____

Infancy and 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 _____
_____
☐ Other chronic medical problems _____
_____
Has your child ever been hospitalized?
☐ No ☐ Yes Why? _____
Previous surgeries: _____
Please list any specialists, including counselors, your child is currently seeing and reason:_____
_____

Developmental
Do you have concerns about any of the following:
☐ The way your child uses his/her arms, fingers or legs
☐ Speech problems
☐ Vision (Are you concerned about your child's vision?)
☐ Hearing (Are you concerned about your child's hearing?)

Social Emotional/Stress Indicators
Parent(s)/Caretaker(s) working outside home? ☐ Yes ☐ No
Child care? ☐ Yes ☐ No
Who do you call for help? _____
Has your child lived anywhere but with parents/caregivers? ☐ Yes ☐ No
Is there stress in the home? ☐ Yes ☐ No
Does your child have problems with sleeping or nightmares? ☐ Yes ☐ No
Does your child have a bad temper/breath holding/jealousy? ☐ Yes ☐ No
Does your child bite their nails or suck their thumb? ☐ Yes ☐ No
Does your child have depression/anxiety? ☐ Yes ☐ No
Does your child have ADD/ADHD? ☐ Yes ☐ No

Exposure Risks
☐ Passive smoke ☐ Cigarettes ☐ E-Cigs ☐ Chew
☐ Alcohol ☐ Other drugs_____
☐ Access to weapons ☐ Has a weapon(s)

☐ Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____
Utilize a car or booster seat? ☐ Yes ☐ No
Wears protective gear, including seat belts? ☐ Yes ☐ No
Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Medications
Current medications and dose: _____
_____
Vitamins: _____
Herbs/home remedies: _____
Over the counter: _____
Allergies/reactions to medications or vaccines: _____
_____

Nutrition and Feeding
☐ Has your child had any feeding/dietary problems? _____
_____
☐ Unexplained weight gain
☐ Unexplained weight loss
☐ Food allergies: _____
☐ Participates in WIC

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? _____
Water source: ☐ City ☐ Well

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	☐	☐	☐	☐
Drug and alchol use	☐	☐	☐	☐
Diagnosed mental condition	☐	☐	☐	☐

Other _____

Other Concerns/Issues:

Reviewed by: _____

Date: _____

Some responses may indicate adverse childhood experiences and may require further evaluation. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. **For assistance phone 844-HELP4WV (844-435-7498).**