EPSDT/HealthCheck Health History Form 0-6 Years

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

Your Name: ______________ **Relationship to Child:** ______________ **Child's Age:** ______

Child's Health History

Pregnancy and Birth

Medical problems during pregnancy? ______________

In utero substance exposure? ______________

Maternal Hep C exposure? ______________

Where was the child born? ______________

Delivered by: ☐ Vaginal ☐ C-section

Why C-section? ______________

Birth Weight: ________ Birth Length: ________

High Birth Score: ______________

☐ 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 ______________

☐ 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

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

☐ Vision (Are you concerned about your child's vision?)

☐ Hearing (Are you concerned about your child's hearing?)

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 use hours per day ______________

Is violence at home a concern? ☐ Yes ☐ No

Child's Health History

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 ☐ Yes ☐ No

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	☐	☐	☐	☐
Postpartum depression	☐			☐
Depression/anxiety	☐	☐	☐	☐
Diagnosed mental condition	☐	☐	☐	☐
Drug and/or alchol use	☐	☐	☐	☐

Other: ______________

Other Concerns: ______________

Reviewed by: ______________

Date: ______________