EPSDT/HealthCheck Health History Form 0-6 Years

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

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

Child's Health History

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 _____

_____

☐ Depression/anxiety _____

☐ ADD/ADHD_____

☐ 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:

☐ 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? ☐ 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

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	☐	☐	☐	☐
Diagnosised mental condition	☐	☐	☐	☐

Other _____

_____

Other Concerns:_____

_____

_____

Reviewed by: _____

Date: _____

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH
West Virginia HealthCheck Program