EPSDT/HealthCheck Health History Form 7-20 Years

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

Your Name: _____ **Relationship to Child:** _____

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
☐ 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? _____

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	☐	☐	☐	☐

Other _____

Other Concerns:_____
_____

Reviewed by: _____

Date: _____