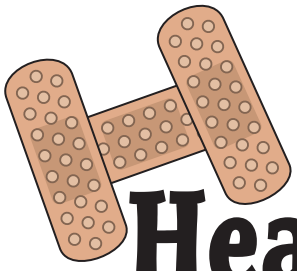

HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Pediatric Health History

Child's name_____

☐ Male ☐ Female Date of birth _____

List Medications child is currently taking. *Include vitamins, fluoride, iron, or over-the-counter medications.*

Medication Dose Number per day

_____

_____

_____

Yes No Does child have any allergies to medications? If yes, what medications? _____

_____

Yes No Does child have any allergies to food? If yes, what foods? _____

_____

Yes No Does child have any other allergies? (i.e. insect bites, chemicals, etc.) If yes, what?

_____

Birth, Prenatal, and Preschool History

Child's birth weight _____

Yes No Was child full term (38-40 wks. gestation)? If no, how many weeks gestation was child when born? _____

Yes No Were there any problems at birth? If yes, please list _____

_____

Yes No Were there any health problems with child as a newbom? If yes, please list _____

_____

Yes No Did child have any health problems from ages 1-5? Please list _____

_____

Yes No Were there any concerns about your child's development (physical growth, coordination, language/verbal, and/or social skills) between the ages of 1 and 5? Please explain _____

_____

_____

Illnesses

Yes No Has child ever been hospitalized?
If yes, why?_____
when?_____
where? _____

Yes No Has child had any surgeries? If yes, what? _____
when?_____
where? _____

Yes No Has child ever been diagnosed with a chronic or serious Illness? (i.e. asthma, diabetes, epilepsy.) If yes, what illness?_____

What's the sickest child has ever been?

Please list any other illnesses or conditions child has or has had (i.e. chicken pox, measles, mumps, rheumatic fever, eczema, headaches, anemia, frequent ear infections, learning difficulties, hay fever, etc.)

_____ when? _____
_____ when? _____
_____ when? _____
_____ when? _____

Yes No Has child ever been in an accident or broken any bones? If yes, please explain

_____

Yes No Has child ever had a head injury/concussion? If yes, date _____
Symptoms and how long they lasted _____

Yes No Does child wear glasses or contact lenses?

Date of last eye exam _____

Date of last dental exam _____

Date of last physical exam_____

Please list any other health concerns _____

_____

_____

_____

Family Health History Have any family members had any of the following?

Yes	No	Died suddenly under age 50?	If yes, what relative?_____
Yes	No	Allergies?	If yes, what relative?_____
Yes	No	Anemia?	If yes, what relative?_____
Yes	No	Asthma?	If yes, what relative?_____
Yes	No	Birth defects?	If yes, what relative?_____
Yes	No	Bleeding disorder?	If yes, what relative?_____
Yes	No	Cancer/leukemia?	If yes, what relative?_____
Yes	No	Diabetes?	If yes, what relative?_____

Yes	No	Lung trouble?	If yes, what relative?_____
Yes	No	Drug or alcohol problem?	If yes, what relative?_____
Yes	No	Epilepsy/seizures?	If yes, what relative?_____
Yes	No	Glaucoma?	If yes, what relative?_____
Yes	No	Heart attack?	If yes, what relative?_____
Yes	No	Heart trouble?	If yes, what relative?_____
Yes	No	High Mood pressure?	If yes, what relative?_____
Yes	No	Kidney disease?	If yes, what relative?_____
Yes	No	Liver disease?	If yes, what relative?_____
Yes	No	Mental illness?	If yes, what relative?_____
Yes	No	Migraine headaches?	If yes, what relative?_____
Yes	No	Ulcer?	If yes, what relative?_____
Yes	No	Stroke?	If yes, what relative?_____
Yes	No	Suicide?	If yes, what relative?_____
Yes	No	Thyroid disease?	If yes, what relative?_____
Yes	No	Tuberculosis?	If yes, what relative?_____
Yes	No	High blood cholesterol?	If yes, what relative?_____
Yes	No	Other illnesses that run in family? Please list_____	
		_____	

School

Grade _____

Favorite Subjects _____

School activities involved in_____

Yes No Any problems at school? Please explain _____

_____

Social

	Name	Age	Occupation	Relationship to child
Who lives with child?	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____
	_____	____	_____	_____

Yes No Any recent changes in the child's home/family environment? _____

Yes No Food insecurity – within the last 12 months did you run out of food or not have enough money for food? _____

What are the child's hobbies?_____

What sports/physical or community activities is the child involved in?_____

_____

What protective wear does child use during sports/activities (bike helmet, elbow pads, knee pads, etc.)? _____

Yes No Does child wear a safety belt when in a vehicle? If yes, is it ☐ regular or ☐ occasional use?_____

Yes No Are guns kept in the home? If yes, are they stored ☐ loaded or ☐ unloaded? ☐ Locked or ☐ unlocked?_____

Yes No Does anyone in the home smoke cigarettes?

Vaccination Record *include copy of vaccination record if school does <u>not</u> already have it.*

Signature of parent/guardian _____

Date_____Relationship to child _____

Thank you for taking the time to complete this form.

Date _____

Reviewed by_____