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 not already have it.*

Signature of parent/guardian ____

Date________________________Relationship to child ______________________________

Thank you for taking the time to complete this form.

Date ____________________________________

Reviewed by________________________________