Northwest Colorado Health
CHILD HEALTH HISTORY FOR CHILDREN UNDER 18 MONTHS OF AGE

Part of visiting your doctor is so that he/she can give you information, referrals and educational materials that help your family. The following form is to help guide the staff as to the unique needs of your own chi

CHILD'S NAME _____ BIRTHDATE _____
TODAY'S DATE _____ CHILD'S AGE _____
NAME OF PERSON COMPLETING FORM _____ _____
RELATIONSHIP TO CHILD _____

Circle One

1. Has your child been getting medical care at another office prior to this? YES NO
   If yes, where? _____

2. Is your child up to date on immunizations? YES NO
   Do you have a shot record? YES NO
   If no, what location were the shots given? _____

3. Does your child have any allergies? YES NO
   If yes, to what? _____

4. Pregnancy
   Did you receive prenatal care? YES NO
   If yes, where? _____

   Please list any complications _____

   During the pregnancy, did you
   a. Smoke cigarettes? If yes, how much? YES NO
   b. Drink alcohol? If yes, how much? YES NO
   c. Take any drugs or medications? YES NO
      If yes, which one? _____

5. Delivery
   Where was the baby born? _____
   Was the delivery vaginal or C-section? (circle one)
   _____ Early How Much? _____
   _____ On Time
   _____ Late How Much? _____

6. After Delivery
   How many days did your baby stay in the hospital ? _____
   How did you feed your baby?
   _____ Breast How Long? _____
   _____ Bottle How Long? _____

   Did the baby have any problem in hospital? YES NO
   If yes, what? _____

7. Has your child had any of the following problems?
   Jaundice (yellow) YES NO
   Colic YES NO
   Breathing problems YES NO
   Feeding problems YES NO
   Poor growth YES NO
   Ear infections YES NO
   Sleep problems YES NO
   Slow development YES NO

8. Has your child ever had surgery? YES NO
   If yes, why? _____

9. Has your child ever stayed over night in the hospital besides birth? YES NO
   If yes, why? _____

10. Has your child ever had a serious accident? YES NO
    If yes, why? _____

11. Have any of your child's relatives (such as brothers, sisters, parents, or relatives of either parents has any of the following? If yes, please explain.)

   Allergies YES NO
   Asthma YES NO
   Birth defects YES NO
   Bleeding disorders YES NO
   Cancer YES NO
   Diabetes YES NO
   Deafness (in young people?) YES NO
   Epilepsy (seizures) YES NO
   Tuberculosis (TB) YES NO
   Heart defects YES NO
   Death under the age of 50 from heart attack YES NO
   High blood pressure YES NO
   Hepatitis (liver disease) YES NO
   Kidney disease YES NO
   Thyroid problems YES NO
   Physical handicaps YES NO
   Mental retardation YES NO
   Mental illness YES NO
   Problems with alcohol YES NO
   Drug related problems YES NO

12. Are you a single parent? YES NO
    If yes,
    a. Does your child visit the absent parent? YES NO
    b. Do you feel comfortable with your child's safety when your child visits the absent parent? YES NO
    c. Do you have anyone available to help you with your child? YES NO

13. Please list the name, age and relationship of all other household members. _____
    _____
    _____
    _____

14. Does anyone in your household smoke? YES NO
15. Do you have any guns in your house? YES NO
16. Has your child ever been abused mentally, physically, or sexually? YES NO

Parent's Signature _____