SCHOOL BASED HEALTH CARE PEDIATRIC PATIENT HISTORY

First Choice Health Centers
For All Your Health Care Needs

SBHC: ☐ New Patient ☐ Established Patient Today's Date: ______________

Parent(s) Name: ____

Child's Full Name: ______________________________ Date of birth: __________ Gender ☐ M ☐ F

Child's Doctor: ______________________________

Child's Medical History ☐ Unknown ☐ No Significant Medical History

Complete below section if child is less than 5 years old or if there was a significant/complicated pregnancy history

Pregnancy/Birth History: *Check all that apply*

Month prenatal care began _______

Weeks of pregnancy _______

Birth Weight _______ ☐ C-Section ☐ Vaginal

Pregnancy Complications:

☐ Infections ☐ Diabetes ☐ Pre-eclampsia

☐ Multiple Births ______________

☐ Other ______________

Birth/Newborn Complications:

☐ Premature? – How early? ______________

☐ NICU stay? – How long? ______________

☐ Other ______________

Medications: ______________

____

During pregnancy, the child's mother:

☐ Smoked - How much? ______________

☐ Drank alcohol - How much? __________

DENTAL APPOINTMENTS ONLY: Fill in only highlighted sections below.

Current Medications:

____

____

Allergies to Medicines: / **Reaction:**

______________ | ______________

______________ | ______________

This Child has been DIAGNOSED with:

- ☐ ADD/ADHD Age:______
- ☐ Allergies/Hay fever Age:______
- ☐ Anemia Age:______
- ☐ Asthma Age:______
- ☐ Autism Age:______
- ☐ Bipolar Disorder Age:______
- ☐ Bleeding/Blood Disorder Age:______
- ☐ Broken Bones - Detail below ______________ Age:______
- ☐ Cancer - Type: ______________ Age:______
- ☐ Celiac Disease Age:______
- ☐ Chicken Pox Age:______
- ☐ Constipation Age:______
- ☐ Depression Age:______
- ☐ Developmental Delay Age:______
- ☐ Diabetes Age:______
- ☐ Frequent Ear Infections Age:______
- ☐ Stomach/Bowel Disorder Age :______
- ☐ Headaches/migraines Age:______
- ☐ Heart Conditions Age:______
- ☐ Infectious Diseases Age:______
- ☐ Learning Disabilty Age:______
- ☐ Pneumonia Age:______
- ☐ Scoliosis (curved spine) Age:______
- ☐ Seizures/epilepsy Age:______
- ☐ Sickle Cell Anemia Age:______
- ☐ Stomach Problems Age:______
- ☐ Skin Issues Age:______
- ☐ UTI/Bladder Infections Age:______
- ☐ Other: ______________ Age:______

Child's SURGERIES ☐ None

- ☐ Appendectomy Age:______
- ☐ Adenoidectomy Age:______
- ☐ Ear Tubes Age:______
- ☐ Other ______________ Age:______
- ☐ Other ______________ Age:______
- ☐ Eye Surgery Age:______
- ☐ Hernia repair Age:______
- ☐ Tonsillectomy Age:______

Child's Hospitalizations:

Hospitalization: ______________________________ Age:______

Hospitalization: ______________________________ Age:______

Hospitalization: ______________________________ Age:______

Child's Family History: Check the diagnoses given to the child's relatives. ☐ Unknown

Please circle relationship:

M=Mother, F=Father, S=Sibling(s), GM = Grandmother, GF=Grandfather, O=Other Relative(s)

Diagnosis of relative:	Relationship to child	Diagnosis of relative:	Relationship to child
☐ ADD	M F S GM GF O	☐ High Blood Pressure	M F S GM GF O
☐ Allergies	M F S GM GF O	☐ High Cholesterol	M F S GM GF O
☐ Anemia	M F S GM GF O	☐ Learning Disability	M F S GM GF O
☐ Asthma	M F S GM GF O	☐ Mental retardation	M F S GM GF O
☐ Autism	M F S GM GF O	☐ Psychiatric Illness (Depression, addiction, etc)	M F S GM GF O
☐ Blood Disorder/ Sickle Cell	M F S GM GF O		
☐ Cancer	M F S GM GF O	☐ Seizures/epilepsy	M F S GM GF O
☐ Celiac Disease	M F S GM GF O	☐ SIDS (crib death)	M F S GM GF O
☐ Diabetes	M F S GM GF O	☐ Stroke before age 55	M F S GM GF O
☐ Stomach/Bowel Disorder	M F S GM GF O	☐ Sudden Death before age 50	M F S GM GF O
☐ Heart disease before age 55	M F S GM GF O	☐ Other ________	M F S GM GF O

Social/Environmental

Child lives w/:

- ☐ Parent(s): ☐ Together ☐ Apart
- ☐ Mother
- ☐ Father
- ☐ Relative ______________
- ☐ Other ______________

Adopted ☐

Smokers live in home with child? ☐ Yes ☐ No

Child attends day care? ☐ Yes ☐ No

Pets in the home? ☐ Yes ☐ No

Well water? ☐ Yes ☐ No

Home built before 1960? ☐ Yes ☐ No

Other ______________