Health Care for the Entire Family

ROANE COUNTY FAMILY HEALTH CARE

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PEDIATRIC HEALTH AND MEDICAL HISTORY

Patient Name: ______________________ **Age:** _____ **DOB:** __________ **SS#:** ______________

Address: ______________________________________ Telephone Number: ______________

Parent/Guardians: ____

Current Circumstances

Child Lives with:
- ☐ Both Parents
- ☐ Single Parent
- ☐ Other
- ☐ Foster Care
- # in Household _______

Barriers to health care:
- ☐ Transportation
- ☐ Money
- ☐ Family applied for CHIPS
- ☐ Inconvenience
- ☐ No Insurance
- ☐ Family applied for Medicaid

Approximate Yearly Income: ______________________

☐ Hispanic ☐ Non-Hispanic

Race: ______________________

Perinatal History

- ☐ Difficult pregnancy/delivery
- ☐ Miscarriages
- ☐ Stillbirths
- ☐ Multiple births

Child's birth weight:
- ☐ Child Full Term
- ☐ Child premature

Condition at birth: ☐ Good ☐ Fair ☐ Poor

Family Health History

Grandparents, Parents, Siblings Had/Have:

- ☐ Heart disease
- ☐ Obesity
- ☐ Asthma
- ☐ Suicide
- ☐ Kidney problems
- ☐ Blood disorder
- ☐ Seizures
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Mental illness
- ☐ Early use of glasses
- ☐ Eating disorder
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Eye disorders
- ☐ Mental retardation
- ☐ High blood pressure
- ☐ Drug/alcohol abuse
- ☐ Cigarette/cigar use
- ☐ Smokeless tobacco
- ☐ Elevated cholesterol

Child Health History

Child Had/Has:

☐ Allergies:

☐ Chronic illness:

☐ Hospitalization:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken pox
- ☐ Hepatitis
- ☐ UTI
- ☐ Rotavirus
- ☐ Eye or Vision problems
- ☐ Ear infection
- ☐ Strep throat
- ☐ Exposure to TB
- ☐ High blood lead level
- ☐ Physical abuse/neglect
- ☐ Meningitis
- ☐ Rubella
- ☐ Frequent URI
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Conjunctivitis
- ☐ Frequent diarrhea
- ☐ Asthma
- ☐ Frequent constipation
- ☐ Seizure
- ☐ Otitis media
- ☐ Other

- ☐ Sexually active
- ☐ Testicular problems
- ☐ Uses contraception
- ☐ Penile discharge
- ☐ Menses
- ☐ Vaginal discharge
- ☐ STD
- ☐ Nipple discharge

Child's Nutritional History

☐ Food allergies: ______________________________________

- ☐ Breast fed
- ☐ Bottle Fed
- ☐ Feeding difficulties
- ☐ Excessive weight gain
- ☐ Excessive weight loss
- ☐ Eating disorder
- ☐ Unusual eating habits
- ☐ Frequent fatigue
- ☐ Iron deficiency anemia
- ☐ Special diet
- ☐ Vitamins

General apperance ☐ Good ☐ Fair ☐ Poor

Patient Name: ____________________ **DOB:** __________

Developmental/Psychological History
Child had/has problems with:

- ☐ Motor skills
- ☐ Sleeping
- ☐ Nightmares
- ☐ Bed wetting (after 6 years)
- ☐ Isolation
- ☐ Hyperactivity
- ☐ Vision
- ☐ Speech
- ☐ Smoking
- ☐ Concentration
- ☐ Hearing
- ☐ Accident prone
- ☐ Appropriate expression of anger
- ☐ Fire setting
- ☐ Sexual acting out
- ☐ Threatens to harm self/others
- ☐ Drug/alcohol use
- ☐ Learning Disabilities
- ☐ Getting along with children/peers
- ☐ Getting along with siblings
- ☐ Getting along with parents/adults
- ☐ Destroys property
- ☐ Tortures animals

Dental History
Child:

- ☐ Has regular dentist
- ☐ Had dental exam in last 6 months
- ☐ Brushes teeth at least twice a day
- ☐ Uses smokeless tobacco

Has a history of:

- ☐ Bleeding gums
- ☐ Swelling mouth sores
- ☐ Redness of mouth

- ☐ Has well water
- ☐ Has city/municipal water
- ☐ Water contains fluoride
- ☐ Uses fluoride supplement

Immunizations

☐ Are up-to-date ☐ Adverse reaction to immunizations

Current Health Assessment

☐ Has regular doctor Doctor's Name: ____________________ Date of last visit: __________

Current health complaints

Current medications: ____________________

Legally Responsible Party Information

Name: ____________________ Home Phone:

Address: ____________________

County: ____________________ Social Security #: ____________________

Employer: ____________________ Work Phone: ____________________

Nearest relative not living with you: ____________________ Phone: ____________________

Whom may we contact in case of an emergency: ____________________ Phone: ____________________
Relationship to Patient: ____________________

Insurance Information

Medicaid or Medicaid HMO name and number: ____________________

Other public Insurance name and number: ____________________

Private Insurance:
Company: ____________________ Group #: __________ Plan ID #: ____________________

☐ Not Insured

Patient Signature: [ ] Date: __________

Guarantor's Signature: [ ] Date: __________