Doctors Care
Accessible Care for the Underserved

CHILD HEALTH HISTORY
18 MONTH TO 12 YEARS

Patients Name_____ **DOB:** _____

1. Has your child had any serious illnesses, accidents or been hospitalized? _____Y_____N
   If yes, what or what for?
   _____
2. When was your child's last tetanus booster? _____
3. Does your child have any allergies to medications? _____
4. Is your child currently taking any medications? _____
5. Have the child's brothers, sisters, parents, or grandparents had any of the following:
   Allergies _____ asthma_____ birth defects_____ diabetes_____ thyroid problems_____ cancer_____
   Death under age 50 from heart attack_____ high blood pressure_____ seizures_____ alcohol problems_____ drug related problems_____ mental illness_____ physical handicaps_____ tuberculosis_____ hepatitis_____.
6. Does anyone in your house smoke? _____Y_____N
7. Have you or anyone in your household ever been sexually or physically abused? _____Y_____N
8. Do you have any of the following problems or issues?
   Acne_____ HIV/AIDS_____ Vision Problems _____ Schools problems_____ Family Problems_____
   Body Development_____ Weight Gain_____ Dental Problems_____ Sexuality Issues _____
9. If your child is being seen today for an illness, what would you have done if the clinic was not in existence?
   a. Gone to another physician?
   b. Gone to the emergency room?
   c. Gone to another walk-in clinic?
   d. Waited as long as possible, until the situation was an emergency?
   e. Done nothing sue to inability to pay?
10. Do you have anything you would like to discuss with the provider in private?
    _____

Parent Signature _____ **Date:** _____

P.A. or M.D. Signature _____ **Date:** _____

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