Ages 11 and older –
Annual Health History Form

Isabella Citizens for Health, Inc.

Patient Name: _____ DOB: __/__/____ **Age**: _____ **Birth Sex**: ☐ Male ☐ Female

Today's Date: ___/___/_____ Preferred Pharmacy: _____

Are you the Child's biological parent, legal guardian, foster parent? (Please circle one)
Do you have the necessary legal paperwork? ☐ Yes ☐ No

Child's Birth History:
Was your child born at/around their due date? ☐ Yes ☐ No, Number of weeks? _____
Were there any major complications surrounding their birth? ☐ No ☐ Yes, _____

Child's Past Medical History: (Check those that are relevant, write in those not on list)
Does your child have any current or chronic medical problems? ☐ No ☐ Yes

Asthma	Heart Problem
Eczema or seasonal allergies	ADD/ADHD
Frequent ear/ throat infections	Other:

Child's Past Hospitalization, Surgeries, and Injuries History (please describe and include dates):
Has your child ever had to sleep in a hospital or had any surgeries? ☐ No ☐ Yes

Problem/Reason	Management (admission/surgery)	Month/Year	Hospital

Child's Medications (include supplements, inhalers, over the counter medications):
Does your child take any medications daily or intermittently? ☐ No ☐ Yes

Name	**Strength**	**How often?**

Child's Allergies: (Please add the reaction)
Does the child have allergies, including medications or foods? ☐ No ☐ Yes

Allergy	Reaction

Family Medical History:

PLEASE SPECIFY FAMILY MEMBER/MATERNAL OR PATERNAL

Medical Problem	Yes	No	Relationship
Heart Disease			
Cancer/ Type?			
High Blood Pressure			
Diabetes			
Kidney Disease			
Headaches			
Neurological disorders/seizures			
Mental Illness			
Learning Disabilities			
Asthma			
Skin disorders			
Thyroid problems			

Other: _____

Child's Immunizations: Are your child's immunizations up to date as far as you know? ☐ Yes ☐ No
If not born/living in Michigan, do you have an updated vaccination record? ☐ Yes ☐ No

Physicians/Other Providers/Specialists Who Have Treated the Child:

_____Dates: _____
_____Dates: _____

Date of last dental exam: _____ Name of Dentist: _____
Date of last vision exam: _____ Name of Eye Doctor: _____

School/Development:

What grade is your child in? _____; School? _____
Has your child repeated grades? ☐ No ☐ Yes, Which one? _____
Does your child have any special needs, an IEP, 504 plan, receive any special education services or therapies? ☐No ☐ Yes, what services? _____
Have you or a provider/teacher had concerns about your child's development/behavior/performance in school? ☐ Yes ☐ No _____

Diet History:

Does/did your child have weight/growth concerns? ☐ Yes ☐ No
Estimated Number of Daily servings:
Fruit/ Vegetables: _____Dairy/Milk: _____Meat/Proteins: _____
Pop/Juice/Sugary drinks: _____ Fast food/Snacks: _____

Social History:

Who lives with the child at home? _____

Are there smokers in the home? ☐ Yes ☐ No *If yes, ☐ Inside ☐ Outside

Are there pets in the home? ☐ Yes ☐ No *If yes, describe: _____

Are there guns in the home? ☐ Yes ☐ No *If yes, are they secured? ☐ Yes ☐ No

Are there smoke detectors in the home? ☐ Yes ☐ No

Are there carbon Monoxide detectors in the home? ☐ Yes ☐ No

Does your child use sunscreen? ☐ Yes ☐ No

Exercise: Does your child get at least 1 hour exercise daily/ participate in sports? _____

Screen time: Number of hours daily? ☐ less than 2 hours ☐ more than 2 hours

Does your child have friends? _____Does your child have bullies? _____

Do you have any other specific concerns about the child you wish to discuss today?

_____

_____

_____

Signature of Parent/Legal Guardian _____Date_____