Ages 10 and younger –
Annual Health History Form

Isabella Citizens for Health, Inc.

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

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

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

**Newborn/Birth History: Mother and Child (At the time mother was pregnant with this child)**
Birth Weight _____ Birth Length_____ Time of Birth_____ Location: _____
Number of pregnancies: _____Number of live births: ____ Number of weeks pregnant at delivery _____
**Complications**: ☐ Pre-term labor ☐ High Blood pressure ☐Diabetes ☐Other_____
**Medications** taken during pregnancy (include supplements, inhalers, over the counter medications):
_____
**Delivery**: ☐ Vaginal birth ☐ C-section ☐ Elective or ☐ Emergency? Reason_____
**Newborn Complications:** _____
**Newborn recommended medications/screenings:**
☐ Vitamin K ☐ Hep B vaccine ☐ Heart Screen ☐ Newborn Screen ☐ Hearing test (Pass or Fail)

**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 | | | |

Other: _____

**Physicians/Other Providers Who Have Treated the Child:**
_____Dates: _____
_____Dates: _____

Date of last dental exam: _____ Name of Dentist: _____

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

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**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 |
|---|---|
| | |
| | |
| | |
| | |

**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

**School/Developmental History:**
Has anyone had concerns about your child's development/behavior? ☐ Yes ☐ No
Was your child delayed in any milestones compared to siblings/peers? ☐ Yes ☐ No
Does your child have any special needs, or receive any therapies?
☐No ☐ Yes, what services? _____

Does your child go to school? ☐ Yes ☐ No Daycare/after school program? ☐ Yes ☐ No
What grade is your child in? _____; School? _____
Has your child repeated any grades? ☐ No ☐ Yes, Which one? _____
Does your child have an IEP, 504 plan or receive any special education services or therapies?
☐No ☐ Yes, what services? _____

**Social History:**

Who lives with the child at home? _____

Are there smokers in the home? ☐ Yes ☐ No *If yes, inside, or outside? ☐ 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 of 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? _____

**Diet History:**

Does/did your child have weight/feeding concerns? ☐ Yes ☐ No

**Infants**

Was/is the child breastfed? ☐ Yes ☐ No Formula fed? ☐ No ☐ Yes; average Ounces per day? _____

Baby food? ☐ No ☐ Yes; # daily servings/jars_____ Solids/table foods? ☐ Yes ☐ No

**Toddlers/Children**

Estimated Number of Daily servings:

Fruit/ Vegetables: _____Dairy/Milk: _____Meat/Proteins: _____

Pop/Juice/Sugary drinks: _____ Fast food/Snacks: _____

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

_____

_____

**Signature of Parent/Legal Guardian _____Date_____**