Unity Care NW

Last revised: 03/2017

CURRENT HEALTH & MEDICAL HISTORY – CHILD: AGE 0-18

Patient Name:_____ **Date of Birth**:_____ **Age**:_____

Reason for Visit: 1. _____2. _____3. _____

MEDICATIONS			ALLERGIES		
List all prescriptions, herbs, vitamins, over the counter medications			Sulfa ☐ Yes ☐ No		Medicines:
Medicine	Strength	Dose	Codeine ☐ Yes ☐ No		
			X-Ray Dye ☐ Yes ☐ No		Foods:
			Aspirin ☐ Yes ☐ No		
			Penicillin ☐ Yes ☐ No		Environmental:
			Bee Stings ☐ Yes ☐ No		
					Other:
CURRENT PHARMACY			☐ No Known Allergies		

PREGNANCY AND BIRTH HISTORY (Ages 0-1 Year)	
Was baby born on time? ☐ Yes ☐ No If no, how many weeks early? Or Late? Pregnancy # Baby born by ☐ C/S ☐ Vaginal Delivery ☐ Forcepts ☐ Vacuum Extraction	Did baby's mother have any of the following during pregnancy? ☐ Anemia ☐ Hep B or Hep C ☐ Diabetes ☐ HIV/AIDS ☐ Fevers ☐ Group B Strep ☐ STD/STI (Herpes, Gonorrhea, Chlamydia, Syphilis, HPV)
Birth Weight: lbs oz	Did baby have any problems after birth? ☐ NICU Admission ☐ Phototherapy for Jaundice ☐ Oxygen Needed ☐ Antibiotics Given ☐ Cardiac / Heart Condition ☐ Other: _____
Did baby pass hearing test? ☐ Yes ☐ No	
Did baby pass Critical Congenital Heart Disease Screening? ☐ Yes ☐ No	
Was Hepatitis B Vaccine given? ☐ Yes ☐ No	
During pregnancy, did mother use any of the following: ☐ Tobacco (smoking) ☐ IV Drugs ☐ Cocaine / Sedative ☐ Alcohol ☐ Marijuana ☐ Narcotics / Methadone ☐ Other: _____ ☐ Prescription Medications: _____ ☐ Over the Counter Medications: _____	

PAST MEDICAL HISTORY		
☐ Anemia ☐ Bleeding problem ☐ Clotting disorder ☐ Asthma ☐ Bronchitis ☐ Recurrent cough ☐ ADHD/ADD ☐ Bedwetting over age 5 ☐ Birth Defects ☐ Blood transfusion ☐ Broken bones/fractures ☐ Cancer ☐ Chicken Pox ☐ Concussions ☐ Dental decay/ cavities ☐ Depression ☐ Anxiety ☐ Other psychiatric condition	☐ Developmental delay ☐ Diabetes ☐ Ear Infections ☐ Sinus Infections ☐ Genetic disorder ☐ GI: Reflux ☐ GI: Chronic constipation ☐ Headaches ☐ Heart conditions/Heart Murmur ☐ High blood Pressure ☐ High Cholesterol ☐ Immune Problem ☐ Injuries (severe) ☐ Kidney/Bladder problems ☐ Overweight ☐ Pneumonia ☐ Seizures ☐ Skin problems/Eczema	☐ Sleep problems ☐ Snoring ☐ Thyroid Condition ☐ Endocrine Condition ☐ Tuberculosis ☐ Underweight ☐ Unexplained fainting ☐ Urinary infections ☐ Vision problems ☐ Hearing problems ☐ Other _____ ☐ Other _____ For Females: ☐ Onset of periods? Age of Onset: _____ Duration: _____ Regular ☐ Yes ☐ No
Does child see any specialists :		
Does child receive any therapies (OT/PT/Speech) :		

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HOSPITALIZATIONS / SURGERIES	
Has the child had any hospitalizations? ☐ Yes ☐ No	Has the child had any surgeries? ☐ Yes ☐ No

Reason	Age	Date	Surgery	Age	Date
			Adenoidectomy		
			Circumcision		
			Inguinal Hernia		
			Nasolacrimal Duct Probe		
			Strabismus		
			Heart Surgery		
			Myringotomy Tubes		
			Tonsillectomy		
			Other:		
			Other:		

FAMILY HISTORY									
Disease or Condition	**Father**	**Mother**	**Paternal Grandfather**	**Paternal Grandmother**	**Maternal Grandfather**	**Maternal Grandmother**	**Brother**	**Sister**	**Other**
ADHD									
Autism									
Learning Disorders									
Alcoholism									
Allergies									
Asthma									
Anxiety									
Bipolar Disorder									
Birth defects/genetic disease									
Bleeding Disorder									
Cancer before age 50 years; Type									
Childhood heart disease/defect									
Cholesterol >240 or high triglycerides									
Clotting disorder									
Deafness/hearing problems									
Dental Disease/cavities									
Depression									
Diabetes									
Died before age 50 years of heart condition or heart attack or sudden unexplained death									
Drug problem									
Epilepsy/Seizures									
GI: Crohn's/ Ulcerative colitis									
Headaches									
Hepatitis									
HIV									
Hypertension/High Blood Pressure									
Kidney disease									
Migraines									
SIDS/ Sudden infant death syndrome									
Stroke									
Thyroid problem									
Tuberculosis or Immune Disorder									
Other									

SOCIAL HISTORY	
Child lives with: ☐ Mother ☐ Stepmother ☐ Other ☐ Father ☐ Stepfather ☐ Sister ☐ Grandparent ☐ Brother ☐ Fosterparent What is child's living situation if not with biologic parents: ☐ Single Custody ☐ Joint Custody ☐ Lives with Adoptive Parent ☐ Foster Family ☐ Other Relative	Mothers Age: Occupation: Fathers Age: Occupation: School / Daycare Attendance? ☐ Yes ☐ No Is the child in special classes in school? ☐ Yes ☐ No If yes: _____ Does the child have an individualized education program (IEP)? ☐ Yes ☐ No Pets in home? ☐ Yes ☐ No If yes: _____

Signature:_____ **Date:** _____