

Pediatric Health History Form - Children with Special Health Care Needs - Page 1 of 3

Patient Name: _____

Date of Birth: _____

Your relationship to child:

Child's previous doctor/primary care provider:

Chronic Medical Problems

Chronic (daily) medications

Specialists involved (example, pulmonologist for asthma)
 none specify: _____

Allergies:
 none specify: _____

Previous Hospitalizations:
 none specify: _____

Severe illnesses, injuries, broken bones, etc.
 none specify: _____

Vaccinations/Immunizations:
 up to date delayed
 I have concerns about vaccines

Has your child been seen by a dentist?
 yes no
date of last visit: _____

Do you have any concerns about your child's development?
 none delayed
 SLP ___ times weekly/monthly
 OT ___ times weekly/monthly
 PT ___ times weekly/monthly
 other therapies _____

When was your child's last well check-up?

Patient Name: _____

Date of Birth: _____

Pregnancy & Birth:

Birth hospital or place of birth: _____

Is the child yours by:
 birth adoption
 stepchild other: _____

Mother's age at the birth of child: _____

Please indicate any problems during pregnancy
 none specify: _____

Please list any medications other than vitamins
 none specify: _____

Pregnancy duration:
 full-term (38-42 weeks)
 premature, specify: _____ weeks

Birth Weight: _____ lbs. _____ oz.

Delivery by:
 vaginal C-section
reason for C-section _____

Apgars scores:
1 min: _____ 5 min: _____

Problems in the birth hospital (jaundice, fever, etc)
 none specify: _____

Please note other important pregnancy & birth facts:

Feeding schedule

table foods
 supplements: (list) _____

npo Formula: _____
Amount: _____
Frequency: _____

**Please describe any areas where assistance is needed:
(DME, services, therapies, etc.)**

Medical Equipment:

- apnea monitor SVN/nebulizer machine
- home oxygen pulse oximetry
- suction diapers from a DME vendor
- feeding pump lift
- stander or walker vehicle adaptation
- bath chair
- other adaptive equipment
- AFO's/SMO's
date of last refit: _____
- augmented communication (DynaVox, etc.)
(list) _____
- wheelchair
date of last refit: _____
- tracheostomy
size: _____
- G-tube Bard Mickey
size: _____
- Home ventilator
settings: _____

- other _____

Durable Medical Equipment Vendors:

Services:

- Habilitative therapies Early Intervention/AzEIP
- Home nursing DDD
- Respite care ALTCS

Case Management contacts

Patient Name: _____

Date of Birth: _____

Family History

Are the child's parents alive and in good health?

yes specify: _____

Are the child's siblings alive and in good health?

yes specify: _____

Does your child have any brothers or sisters?

Name age relationship (note if step- or half-sibling)

Please list any of your child's blood relatives who have any of the following medical conditions:

- AIDS/HIV _____
- Alcoholism _____
- Allergies/Asthma _____
- Arthritis _____
- Blood disorders _____
(bleeding/clotting problems) _____
- Cancer (what type) _____
- Cystic Fibrosis _____
- Diabetes _____
- Drug problems _____
- Genetic problems/birth defects _____
- Heart attacks/heart disease _____
- High blood pressure _____
- High cholesterol _____
- Epilepsy/seizures _____
- Kidney disease _____
- Liver disease/Hepatitis _____
- Lung disease _____
- Lupus/other autoimmune diseases _____
- Mental illness _____
(anxiety, depression, suicide) _____
- Muscular dystrophy _____
- Obesity _____
- SIDS _____
- Stroke _____
- Tuberculosis _____
- Other _____

Social History

Who lives at home?

Name relationship to child age

Are your child's parents:

married unmarried

separated divorced

if divorced or separated, when? _____

Mother's occupation: _____

Father's occupation: _____

Guardian's occupation: _____

Where is the child during the day?

parents or guardian

babysitter/daycare

preschool/school

Grade: _____

School: _____

Do any of the adults living with the child smoke?

no yes Outside? _____

Is there a gun in the home?

no yes Locked? _____

Is there a pool on your property?

no yes Fenced? _____

Are there any pets in the home?

no yes _____

Does the child use a carseat in the car?

no yes

Is there any violence in the home?

no yes

Has the child witnessed or suffered abuse?

no yes