



EPSDT HEALTH HISTORY

NAME _____

SEX BIRTH [] MALE [] FEMALE	RACE	SOCIAL SECURITY NUMBER	DATE OF
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Please list all people in household:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father _____			
Mother _____			
Other _____			
Other _____			
Other _____			
Other _____			

Have there been any recent major changes or stresses in the child's life? [] Yes [] No

If YES, explain _____

Does child go to a baby sitter, preschool or day care regularly? [] Yes [] No

BIRTH HISTORY

Birthweight _____ Length _____ Place of Birth _____

During the pregnancy did the mother see a doctor regularly? [] Yes [] No

During pregnancy did the mother: (If YES, explain) Explanation

Have any medical problems? [] Yes [] No _____

Smoke or drink? [] Yes [] No _____

Use any medications? [] Yes [] No _____

Use alcohol or other drugs? [] Yes [] No _____

Have problems with labor/delivery? [] Yes [] No

How long did the baby stay in the hospital after birth? _____

PAST MEDICAL HISTORY

Is the child's general health: (Check one) [] Good [] Fair [] Poor

Does the child have any allergies? [] Yes [] No _____

Is the child taking medications? [] Yes [] No _____

Please list any hospitalizations, operations, serious illnesses or accidents with dates.

_____ Date _____

_____ Date _____

Has child ever had any problems with following. If Yes, please explain.

- Eyes/Vision [] Yes [] No _____
- Feet [] Yes [] No _____
- Digestion/Nutrition [] Yes [] No _____
- Ears/Hearing [] Yes [] No _____
- Urine/Kidneys [] Yes [] No _____
- Joints [] Yes [] No _____
- Skin [] Yes [] No _____
- Lungs [] Yes [] No _____
- Teeth [] Yes [] No _____
- Heart [] Yes [] No _____
- Seizures [] Yes [] No _____
- Repeated Infections [] Yes [] No _____

FAMILY HISTORY

Have any of the child’s brothers or sisters died? [] Yes [] No
 (If Yes, give age and cause) _____

Have any of the child’s blood relatives had the following diseases? (If Yes, please list family member)
FAMILY MEMBER

- Heart Disease [] Yes [] No _____
 - Tuberculosis [] Yes [] No _____
 - High Blood Pressure [] Yes [] No _____
 - Kidney Disease [] Yes [] No _____
 - Allergies/Asthma [] Yes [] No _____
 - Cancer [] Yes [] No _____
 - Diabetes [] Yes [] No _____
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- Mental/Emotional Problems [] Yes [] No _____
 - Sickle Cell [] Yes [] No _____
 - Seizures [] Yes [] No _____

DEVELOPMENT

Do you have any concerns about the following? If Yes, please explain.

- Development [] Yes [] No _____
- Behavior [] Yes [] No _____
- Eating Habits [] Yes [] No _____
- Sleeping Habits [] Yes [] No _____
- School Experience [] Yes [] No _____
- Bathroom/Toilet Habits [] Yes [] No _____
- Discipline [] Yes [] No _____
- Other (explain) [] Yes [] No _____

IMMUNIZATIONS

NAME	DATE	DATE	DATE	DATE	DATE	REACTIONS
DPT						
TOPV						
MMR						
TB (TEST)						
HIB						

Reviewed by _____ Date _____

