GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

# Health History
## CHILD (0-2 years)

**Last Name:**_____ **First Name:**_____ **DOB:** _____

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Relative, relationship:_____

☐ Adopted (year joined family:_____ ☐ Foster (year joined family:_____

**Birth Medical History**:

Birth weight:_____ Pregnancy lasted: ☐ Full-term ☐ Pre-Term # of weeks:_____

Type of delivery: ☐ Vaginal ☐ C-Section Type of pregnancy: ☐ Single ☐ Twin ☐ Triplet +

Mother's age at time of birth:_____ # of pregnancies:_____ # of deliveries:_____

**Past Medical History**: (please mark any that apply and explain)

| | | |
|---|---|---|
| ☐ Abdominal complaints | ☐ Colic | ☐ Heart condition / Murmurs |
| ☐ Allergies | ☐ Diabetes | ☐ Kidney disease |
| ☐ Asthma / Wheezing | ☐ Ear infections | ☐ Thyroid |
| ☐ Cancer (type:_____) | ☐ Headaches | ☐ Urinary tract infections |

**Explanation/Other**:_____

**Any serious injuries**: ☐ Concussions ☐ Fractures Other (specify):_____

*If any checked*, how many:_____ Age(s) when injured:_____

**Past Surgeries / Hospitalizations**: (please list any surgeries or hospitalizations, date, and reason)

| Surgery / Hospitalization | Date | Reason |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**Medications**: (please include over-the-counter, herbal supplements, and vitamins)

☐ No medications at all ☐ See attached medications list

| Medication | Dose | How Often |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**Allergies:** ☐ Drug/medication allergies (*please explain below*):

**Explanation:**_____

_____

_____

☐ No known drug allergies

☐ Animals ☐ Food

☐ Environmental

☐ No allergies at all

Turn over for page 2.

**Today's Date:**_____

**Other providers involved in child's care**: (please include dental, therapists, specialists, etc.)

| Name | Specialty | Reason / Last visit |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

**Review of Systems**: (please check system(s) and circle the condition(s) that apply today)

- ☐ **Ears**: Hearing loss, ringing, pain, discharge
- ☐ **Eye**: Visual change, blurred vision, glasses
- ☐ **Endocrine**: Heat/cold intolerance, excessive sweating, frequent urination, excessive thirst, thyroid problems, diabetes
- ☐ **GI**: Stomach-ache, nausea, vomiting, diarrhea, constipation, blood in stool
- ☐ **General**: Fever, chills, weight change, weakness
- ☐ **Genital**: Discharge, sores, itchy
- ☐ **Head**: Trauma, concussion, headache
- ☐ **Heart**: Murmurs, palpitations, swelling, trouble lying flat
- ☐ **Hematologic**: Anemia, easy bruising, bleeding, transfusions
- ☐ **Lungs**: Short of breath, wheeze, cough, asthma
- ☐ **Mouth / Throat**: Sore, hoarseness, cavities, impetigo, blisters
- ☐ **Muscles / Bones**: Weakness, pain, joint stiffness
- ☐ **Neuro**: Dizziness, loss of sensation, weakness, tremor, tingling, fainting
- ☐ **Nose**: Runny, bloody, sneezing, itchy
- ☐ **Psychiatric**: developmental delays, autism, potty training difficulty, speech
- ☐ **Skin**: Rash, hair change, nail change, moles, diaper rash
- ☐ **Urine**: Painful, frequency, discharge, blood
- ☐ **Vessels**: Leg swelling

**Explanation/Other**:_____

**Family History:** (please mark the illnesses/conditions that <u>any members</u> of your family may have/had)

| | Diabetes | Heart Disease | High BP | Stroke | High Cholesterol | Depression/ Mental Illness | Thyroid | Cancer (type) | Other (list) |
|---|---|---|---|---|---|---|---|---|---|
| **Mother** ☐Alive ☐Deceased | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | |
| **Father** ☐Alive ☐Deceased | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | |
| **Sibling(s)** ☐Alive ☐Deceased | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | |

**Health Maintenance**:

Is child up to date with childhood immunizations? ☐ Y ☐ N ☐ Unknown ☐ N/A

*If no / unknown,* would you like to discuss vaccines that are due today? ☐ Y ☐ N

**Social History**:

Parents Marital Status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Widowed

Childcare away from parents: ☐ None ☐ Relative ☐ Nanny ☐ Private sitter ☐ Daycare

Child's diet is: ☐ Breastfed ☐ Formula ☐ Solids ☐ Special diet (vegan, diabetic, gluten-free)

Play time / Exercise: ☐ None ☐ Occasional ☐ Moderate Potty training: ☐ Y ☐ N

Pets in the home: ☐ Y ☐ N *If yes,* what types_____

Smoke exposure in the home: ☐ Y ☐ N $CO_2$ detectors in the home? ☐ Y ☐ N

Guns in the home: ☐ Y ☐ N Where stored: ☐ Inside ☐ Outside Locked: ☐ Y ☐ N

Bike helmet use: ☐ Always ☐ Only w/strider or motorized ☐ No, because in bike trailer ☐ Never

Car seat used: ☐ Y ☐ N