



HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Pediatric Health History

Child's name _____

Male Female Date of birth _____

List Medications child is currently taking. *Include vitamins, fluoride, iron, or over-the-counter medications.*

Medication	Dose	Number per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes No Does child have any allergies to medications? If yes, what medications? _____

Yes No Does child have any allergies to food? If yes, what foods? _____

Yes No Does child have any other allergies? (i.e. insect bites, chemicals, etc.) If yes, what? _____

Birth, Prenatal, and Preschool History

Child's birth weight _____

Yes No Was child full term (38-40 wks. gestation)? If no, how many weeks gestation was child when born? _____

Yes No Were there any problems at birth? If yes, please list _____

Yes No Were there any health problems with child as a newborn? If yes, please list _____

Yes No Did child have any health problems from ages 1-5? Please list _____

Yes No Were there any concerns about your child's development (physical growth, coordination, language/verbal, and/or social skills) between the ages of 1 and 5? Please explain _____

Illnesses

Yes No Has child ever been hospitalized?
 If yes, why? _____
 when? _____
 where? _____

Yes No Has child had any surgeries? If yes, what? _____
 when? _____
 where? _____

Yes No Has child ever been diagnosed with a chronic or serious illness? (i.e. asthma, diabetes, epilepsy.) If yes, what illness? _____

What's the sickest child has ever been?

Please list any other illnesses or conditions child has or has had (i.e. chicken pox, measles, mumps, rheumatic fever, eczema, headaches, anemia, frequent ear infections, learning difficulties, hay fever, etc.)

_____ when? _____
 _____ when? _____
 _____ when? _____
 _____ when? _____

Yes No Has child ever been in an accident or broken any bones? If yes, please explain

Yes No Does child wear glasses or contact lenses?
 Date of last eye exam _____
 Date of last dental exam _____
 Date of last physical exam _____
 Please list any other health concerns _____

Family Health History Have any family members had any of the following?

Yes No Died suddenly under age 50? If yes, what relative? _____

Yes No Allergies? If yes, what relative? _____

Yes No Anemia? If yes, what relative? _____

Yes No Asthma? If yes, what relative? _____

Yes No Birth defects? If yes, what relative? _____

Yes No Bleeding disorder? If yes, what relative? _____

Yes No Cancer/leukemia? If yes, what relative? _____

Yes No Diabetes? If yes, what relative? _____

Yes No Lung trouble? If yes, what relative? _____

- Yes No Drug or alcohol problem? If yes, what relative? _____
- Yes No Epilepsy/seizures? If yes, what relative? _____
- Yes No Glaucoma? If yes, what relative? _____
- Yes No Heart attack? If yes, what relative? _____
- Yes No Heart trouble? If yes, what relative? _____
- Yes No High Mood pressure? If yes, what relative? _____
- Yes No Kidney disease? If yes, what relative? _____
- Yes No Liver disease? If yes, what relative? _____
- Yes No Mental illness? If yes, what relative? _____
- Yes No Migraine headaches? If yes, what relative? _____
- Yes No Ulcer? If yes, what relative? _____
- Yes No Stroke? If yes, what relative? _____
- Yes No Suicide? If yes, what relative? _____
- Yes No Thyroid disease? If yes, what relative? _____
- Yes No Tuberculosis? If yes, what relative? _____
- Yes No High blood cholesterol? If yes, what relative? _____
- Yes No Other illnesses that run in family? Please list _____

School

Grade _____

Favorite Subjects _____

School activities involved in _____

Yes No Any problems at school? Please explain _____

Social

	Name	Age	Occupation	Relationship to child
Who lives with child?	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Yes No Any recent changes in the child's home environment? _____

What are the child's hobbies? _____

What sports/physical or community activities is the child involved in? _____

What protective wear does child use during sports/activities (bike helmet, elbow pads, knee pads, etc.)? _____

Yes No Does child wear a safety belt when in a vehicle? If yes, is it regular or occasional use? _____

Yes No Are guns kept in the home? If yes, are they stored loaded or unloaded? Locked or unlocked? _____

Yes No Does anyone in the home smoke cigarettes?

Vaccination Record

Dates

DTaP _____

Polio _____

MMR _____

Hepatitis B _____

Tetanus Booster(s) _____

Others:

Varicella (chicken pox) _____

Influenza _____

Pneumococcal _____

PPD (tuberculosis skin test) _____

Yes No Any history of a positive PPD? If yes, when and how treated? _____

Signature of parent/guardian _____

Date _____ Relationship to child _____

Thank you for taking the time to complete this form.

Date _____

Reviewed by _____