Cornerstone Family Practice <u>4-12 years</u> Health History Form

Name:____

Date Today:____________________ Date of Birth:____________________

Age of Child today____

Who are the child's primary caregivers?______________________________

Please list siblings names and ages.______________________________

Any behavioral problems?____________________________________

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Nutrition: Is your child eating a balanced diet?________________________

Is your child allowed to eat "junk foods" ?____________________________

Are they taking supplemental vitamins?______________________________

How many meals per day?__________ Any difficulties?____________________

Sleep: How many hours of sleep does your child get per night?____________________

Elimination: Is your child toilet trained?__________ Occasional accidents?__________

Is bed wetting a problem?____________________________________

Social: Is your child in school?__________ What grade?____________________

Is your child performing well or poorly in school?________________________

Does your child interact well or poorly with peers?________________________

Does your child participate in extra-curricular activities? If so , what types?(ex. sports ,hobbies)

____

Medical History: Does your child have any medical problems? Please describe.

1.
2.
3.
4.

Surgical History: Please list any surgeries your child has had and the date.

1.	3.
2.	4.

Immunizations: Is your child up-to-date as far as you know?____________________

Any reactions to immunizations?____________________________________

Medications: Please list any medications your child is taking and dosages.

1.	3.
2.	4.

Allergies: Please list any medication/environmental/food allergies your child has.

1.	3.
2.	4.

Any concerns today?____

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– Turn Over Please –

FAMILY HISTORY: Please list family members with the following diseases

Note relationship to you and whether mother's (M) or father's (F) side of your family.

Alcohol/Drug Abuse	Skin Cancer
Asthma/Allergies	Thyroid Cancer
Birth Defect/Genetic Disease	Depression/Psychiatric Problems
Breast Cancer	Diabetes
Cervical Cancer	Heart Disease/Attack
Colon Cancer	High Blood Pressure
Lung Cancer	High Cholesterol
Ovarian Cancer	Migraines
Prostate Cancer	Stroke