PATIENT NAME	DOB	GENDER ☐ Male ☐ Female

PREGNANCY AND BIRTH HISTORY

Where was child born? _____ ☐ Home ☐ Hospital
Illnesses during pregnancy? ☐ No ☐ Yes
Medications during pregnancy? ☐ No ☐ Yes
Alcohol/drug abuse? ☐ No ☐ Yes
Problems at birth? ☐ No ☐ Yes
Describe: _____
Baby arrived: ☐ On time ☐ Early ☐ Late
Type of delivery? ☐ Vaginal ☐ C-section
Birth weight: _____ Discharge weight: _____
Did baby receive Hepatitis B vaccine at birth? ☐ No ☐ Yes
Newborn hearing screen? ☐ Fail ☐ Pass

PSYCHOSOCIAL HISTORY

Who lives in household? ☐ Mother ☐ Father
☐ Both parents ☐ Stepmother ☐ Stepfather
☐ Other: _____
How many people live in home? _____
Type of residence: ☐ Rent ☐ Own ☐ Shelter
Who cares for child? _____
Date of Birth? Mother: _____
Father: _____
Are child's parents working? Mother ☐ No ☐ Yes
Father ☐ No ☐ Yes
Foster Care? _____ Dates: _____
Other languages? _____

FAMILY HISTORY

Have your child's parents, grandparents, aunts/uncles, sisters/brothers had…

			IF YES, WHO?
Allergies to medicine: _____	☐ No	☐ Yes	_____
Allergies (list): _____	☐ No	☐ Yes	_____
Asthma	☐ No	☐ Yes	_____
TB/lung disease	☐ No	☐ Yes	_____
HIV/AIDS	☐ No	☐ Yes	_____
Suicide attempts	☐ No	☐ Yes	_____
Heart disease	☐ No	☐ Yes	_____
High blood pressure/stroke	☐ No	☐ Yes	_____
High cholesterol	☐ No	☐ Yes	_____
Blood disorders/Sickle Cell	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Seizures	☐ No	☐ Yes	_____
Mental illness	☐ No	☐ Yes	_____
Cancer	☐ No	☐ Yes	_____
Birth defects	☐ No	☐ Yes	_____
Hearing loss	☐ No	☐ Yes	_____
Speech problems	☐ No	☐ Yes	_____
Kidney disease	☐ No	☐ Yes	_____
Alcohol/drug abuse	☐ No	☐ Yes	_____
Hepatitis/liver disease	☐ No	☐ Yes	_____
Thyroid disease	☐ No	☐ Yes	_____
Learning problems/ attention deficit disorder	☐ No	☐ Yes	_____
Family violence	☐ No	☐ Yes	_____
Other: _____			_____

MEDICAL HISTORY

Has your child ever had…

Allergies to medicine: _____	☐ No	☐ Yes
Allergies (list): _____	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Chicken Pox--YEAR: _____	☐ No	☐ Yes
Frequent ear infections	☐ No	☐ Yes
Vision/hearing/speech problems	☐ No	☐ Yes
Skin problems/eczema	☐ No	☐ Yes
TB/lung disease	☐ No	☐ Yes
Seizures/Epilepsy	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes
Heart defects/disease	☐ No	☐ Yes
Liver disease/Hepatitis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Kidney disease/bladder infections	☐ No	☐ Yes
Physical or learning disabilities	☐ No	☐ Yes
Bleeding disorders/Hemophilia	☐ No	☐ Yes
Sexually transmitted diseases	☐ No	☐ Yes
Emotional or behavioral problems	☐ No	☐ Yes
Depression/suicidal thoughts	☐ No	☐ Yes
Hospitalizations/surgeries	☐ No	☐ Yes
Physical/emotional/sexual abuse	☐ No	☐ Yes
Bone or joint injuries	☐ No	☐ Yes
Obesity/eating disorders	☐ No	☐ Yes

Other serious illnesses or injuries: _____

Immunizations current? ☐ No ☐ Yes
Current medication(s)--list: _____
Is your child currently being treated for any medical or behavioral condition? _____

YAVAPAI REGIONAL MEDICAL CENTER
PARTNERS FOR HEALTHY STUDENTS

MEDICAL HISTORY

DEVELOPMENTAL HISTORY

1) Do you believe your child hears normally?	☐ No ☐ Yes	
2) Do you believe your child speaks normally?	☐ No ☐ Yes	
3) Does your child have any behavioral problems?	☐ No ☐ Yes	
4) Do you believe your child's growth is normal?	☐ No ☐ Yes	
5) Has your child been to a dentist?	☐ No ☐ Yes	How long ago?
6) At what age did your child walk?	_____ (months)	
7) At what age did your child speak one word?	_____ (months)	
8) At what age did your child use sentences?	_____ (years)	
9) At what age was your child toilet trained?	_____ (years)	
10) If you do not remember, were there any concerns that your child was developmentally delayed?	☐ No ☐ Yes	

ENVIRONMENTAL/SAFETY HISTORY

1) How many members in the household smoke?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	
2) Do you have any pets in the home?	☐ No ☐ Yes	
3) Does child always wear a helmet when on sports equipment (bicycle, skateboard)?	☐ No ☐ Yes	
4) Does child always wear seat belt?	☐ No ☐ Yes	
5) Do you have problems with your partner or family?	☐ No ☐ Yes	
6) Is alcohol use or illegal drugs a problem in the home?	☐ No ☐ Yes	
7) Do you have unlocked guns in the home?	☐ No ☐ Yes	
8) Do you have problems with living conditions, sleeping arrangements or monetary problems?	☐ No ☐ Yes	
9) Do the adults in the family usually agree on the discipline of this child?	☐ No ☐ Yes	
10) Do you have other concerns about your child?	☐ No ☐ Yes	

COMPLETED BY (PRINT)	SIGNATURE	RELATIONSHIP	DATE

REVIEWED BY (SIGNATURE / TITLE)	DATE