CHILD HEALTH PARTNERS

Patient Name: _____ **Todays Date:** _____

Updated _____ _____ _____

FAMILY HISTORY

Have any family members had the following:

Deafness	Yes	No	Who_____	Comments _____
Nasal Allergies	Yes	No	Who_____	Comments _____
Asthma	Yes	No	Who_____	Comments _____
Tuberculosis	Yes	No	Who_____	Comments _____
Heart disease (before 50 years old)	Yes	No	Who_____	Comments _____
High blood pressure (before 50 years old)	Yes	No	Who_____	Comments _____
High cholesterol	Yes	No	Who_____	Comments _____
Anemia	Yes	No	Who_____	Comments _____
Bleeding disorder	Yes	No	Who_____	Comments _____
Liver disease	Yes	No	Who_____	Comments _____
Kidney disease	Yes	No	Who_____	Comments _____
Diabetes (before 50 years old)	Yes	No	Who_____	Comments _____
Bed-wetting (after 10 years old)	Yes	No	Who_____	Comments _____
Epilepsy or convulsions	Yes	No	Who_____	Comments _____
Alcohol abuse	Yes	No	Who_____	Comments _____
Drug abuse	Yes	No	Who_____	Comments _____
Mental Illness	Yes	No	Who_____	Comments _____
Mental retardation	Yes	No	Who_____	Comments _____
Immune problems, HIV, or AIDS	Yes	No	Who_____	Comments _____

Additional family history

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_____

PAST HISTORY

Does your child have, or has he/she ever had:

Chickenpox	Yes	No	Who_____	Comments _____
Frequent ear infections	Yes	No	Who_____	Comments _____
Problems with ears or hearing	Yes	No	Who_____	Comments _____
Nasal allergies	Yes	No	Who_____	Comments _____
Problems with eyes or vision	Yes	No	Who_____	Comments _____
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	Who_____	Comments _____
Any heart problem or heart murmur	Yes	No	Who_____	Comments _____
Anemia or bleeding problem	Yes	No	Who_____	Comments _____
Blood transfusion	Yes	No	Who_____	Comments _____
Frequent abdominal pain	Yes	No	Who_____	Comments _____
Constipation requiring doctor visits	Yes	No	Who_____	Comments _____
Bladder or kidney infection	Yes	No	Who_____	Comments _____
Bed-wetting (after 5 years old)	Yes	No	Who_____	Comments _____
(For girls) Has she started her menstrual periods?	Yes	No	Who_____	Comments _____
(For girls) Are there problems with her periods?	Yes	No	Who_____	Comments _____
Any chronic or recurrent skin problem (acne, eczema, etc.)	Yes	No	Who_____	Comments _____
Frequent headaches	Yes	No	Who_____	Comments _____
Convulsions or other neurologic problem	Yes	No	Who_____	Comments _____
Diabetes	Yes	No	Who_____	Comments _____
Thyroid or other endocrine problem	Yes	No	Who_____	Comments _____
Any other significant problem	Yes	No	Who_____	Comments _____
Use of alcohol or drugs	Yes	No	Who_____	Comments _____