Dr. Josephine Y. Lee, MS, DC
636-226-5228

Young Child Health History Form

Child's Name:_____ _____
First Middle Last

Child's Address_____

Today's Date_____ _____

Filling out this form

- Answering these questions will help your doctor understand your child's health and how best to treat you.
- If you need help filing out this form:
    - Bring this form with you to your appointment and a nurse will help you.

OR

    - Call Dr. Lee at 636-226-5228 before your appointment and someone can help you over the phone.

Bring to your appointment:

1. This **Child Health History Form** and any other important **medical records.**

2. A complete copy of the child's **immunization records.**

3. Any **medicines the child takes** (prescription, herbal, over-the-counter pills, and creams).

We look forward to working with you!

GENERAL INFORMATION

What is the child's sex? ☐Female ☐Male

Child's Date of Birth_____ current age _____

Is your child **adopted**? ☐No ☐Yes If yes, at what age? _____

Who is filling out this form?
☐Mother

☐Father

☐Other guardian (please explain relationship to child) _____

☐Other (please explain) _____

The child's parents are:

☐Single ☐Married ☐Divorced ☐Separated but not divorced

☐Widowed ☐Living together but not married ☐unknown

Main adult contact for child	**Alternate adult contact for child**
Name: _____	Name: _____
Relation to child: ☐Mother ☐Father ☐Other: _____	Relation to child: ☐Mother ☐Father ☐Other: _____
Address: ☐Same as child's Street address: _____ _____ City: _____ State: _____ Zip: _____	Address: ☐Same as child's Street address: _____ _____ City: _____ State: _____ Zip: _____
Home Phone:	Home Phone:
Cell Phone:	Cell phone:
Work Phone:	Work Phone:

TODAY'S HEALTH PROBLEMS

1. List your child's **main heath problems** (or reasons for visiting the clinic).
☐Routine checkup
☐Immunizations (shots)
☐A health problem (please specify)_____
☐Switching doctors (last doctor _____)

2. How well do you feel your child **acts or behaves**?
☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

MEDICAL HISTORY

3. Has your child ever been a **patient in a hospital** (other than a few days after birth)?
☐No (If no, go to question #9.)
☐Yes (If yes, explain why and when below.)

My child was in the hospital because:	**When**
Example: Bike accident	5 years old

4. Is your child taking any **prescription medicines**?
☐Yes - Please list the child's medicines below or ☐I brought my child's medicines.
☐No. My child does not take any prescription medicines. (If no, go to question #5.)

Name of medicine	**Amount / size of pill**	**How many pills or doses does your child take at**
Example: Dexadrine	10 mg	__1__morning ____noon ____dinner __1__bed
		____morning ____noon ____dinner ____bed
		____morning ____noon ____dinner ____bed
		____morning ____noon ____dinner ____bed

(Please use the back of this form if you have more prescription medicine.)

5. What **over-the-counter medicines**, does your child take regularly?
☐Vitamins
☐Herbal medicine (please list) _____
☐Other (please list) _____
☐None, my child does not take any over-the-counter medicines regularly.

6. Does your child have any **allergic reaction (bad effect)** from any of the following? (Check all that apply.)
☐Outside or Indoor allergies (for example: grass, pollen, cats …)
☐Food Allergies (for example: peanuts, milk, wheat …)
☐Medicine or shots (immunization). (Please list below.)
☐No, my child has no allergies that I know of.

Medicine child is allergic to	**What happens when the child take that medicine**
Example: amoxicillian	Diarrhea (runny poop)

7. Has your child had any of the following **diseases**?

Measles	☐Yes	☐No	☐Don't Know
Mumps	☐Yes	☐No	☐Don't Know
Chicken Pox	☐Yes	☐No	☐Don't Know
Whooping Cough	☐Yes	☐No	☐Don't Know
Rubella	☐Yes	☐No	☐Don't Know
Rheumatic Fever	☐Yes	☐No	☐Don't Know
Scarlet Fever	☐Yes	☐No	☐Don't Know

Add any additional comment below:

8. Please check any of the following **medical problems** that your child has **ever** had.

Has your child **ever** had**:**	
Ear infections	☐Yes ☐No
Nose problems (sinus infections, nose bleeds)	☐Yes ☐No
Eye problems (blurry vision, need to wear glasses)	☐Yes ☐No
Hearing problems	☐Yes ☐No
Mouth or throat problems (Strep throat, swallowing problems)	☐Yes ☐No
Diarrhea (having frequent and runny bowel movements)	☐Yes ☐No
Constipation (problems having a bowel movement (BM))	☐Yes ☐No
Throwing up (vomiting)	☐Yes ☐No
Problems **peeing** (bed wetting, pain when peeing)	☐Yes ☐No
Back problems (crooked back, back pain)	☐Yes ☐No
Growing pains (bone or body pains due to growing)	☐Yes ☐No
Muscle and bone problems (weak muscles, pain in joints)	☐Yes ☐No
Skin problems (acne, flaking skin, rashes, hives)	☐Yes ☐No
Seizures (shaking fits)	☐Yes ☐No
ADD/ADHD (problems paying attention, sitting still)	☐Yes ☐No
Sleeping problems (falling or staying asleep)	☐Yes ☐No
Breathing problems (cough, asthma)	☐Yes ☐No
Warts	☐Yes ☐No
Jaundice (yellow skin)	☐Yes ☐No

SHOTS

9. Has your child received **immunizations (shots)** in the past?
☐No (If no, go to question #10.)
☐Yes
If yes, have you given this office a copy of the immunization (shots) records?
☐Yes (If no, go to question #10.)
☐No

If not, **please give us the name of the doctors' offices or clinics** where your child has received these shots so we can get the records.
Doctor's office/clinic name: _____
Doctor's office/clinic phone number:_____

ABOUT MOM WHEN PREGNANT

The following questions are about the mother of the child during pregnancy and birth.
If you do not know about the pregnancy of the mother, check here ☐ and go to #17.

10. What was the general **health of the mother** during pregnancy?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unknown

11. Were any of the following used **during pregnancy**?

☐ Cigarettes

☐ Alcohol

☐ Illegal drugs (which ones? _____)

☐ Prescription drugs (which ones? _____)

☐ None of the above

12. Did the mother have any of the following **conditions or problems during pregnancy**?

☐ Preeclampsia (high blood pressure) ☐ Diabetes (sugar)

☐ Emotional stress ☐ Injury or serious illness

☐ Unexpected bleeding or spotting ☐ Other _____

13. **Was the birth**:

☐ On the due date

☐ Before the due date (by how much _____)

☐ After the due date (by how much_____)

14. **Was the birth:** ☐ Vaginal ☐ C-Section (surgical cut in the tummy?)

15. **Were any of the following used**?

☐ Pain medicine during birth (epidural)

☐ Tool to help pull baby out (forceps or vacuum)

☐ None

16. Were there any **problems during the birth**? ☐ Yes ☐ No

If yes, please explain: _____

ABOUT THE CHILD AS A BABY

17. Was/is the child **breastfed**? Yes ☐ No ☐ If yes, how long_____

18. In the first **2 months after birth**, did the child have:

☐Jaundice (yellow skin)

☐Colic (upset stomach, crying)

☐Breathing problems

☐Other _____

☐None of the above

19. At what age did the child begin to **crawl**? _____

20. At what age did the child begin to **sit up**? _____

21. At what age did the child begin to **walk**? _____

22. At what age did the child get his/her **first tooth**? _____

23. At what age did the child began to **say words** (mama, dada)? _____

24. How would you rate your **child's health in his or her first year** of life?

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor ☐Unknown

IN SCHOOL AND ATA HOME

25. Does the child go to **school or daycare**? ☐Yes ☐No If yes, what is its name?

_____

26. If your child goes to school or daycare, describe **how your child acts** in school or daycare.

Check all that apply.

☐Nervous, worried ☐Shy, withdrawn, keeps to self

☐Hyper, restless, can't sit still ☐Gets angry easily

☐Pushy, bullies others ☐Scared, fearful

☐Relaxed, calm ☐Moody

☐Social, friendly ☐Happy

27. How are your child's **grades** in school?

☐Excellent ☐OK ☐Poor ☐Does not go to school

28. About how much **exercise** does your child get every day?

☐Less than 30 minutes ☐30 minutes to 1 hour ☐Over 1 hour

29. About how many hours of **TV** does your child watch every day?

☐Less than1 hour ☐1-3 hours ☐More than 3 hours

30. About how many hours is your child on a **computer** every day?

☐Less than 1 hour ☐1-3 hours ☐More than 3 hours

☐Does not have a computer

31. About how many hours does your child **spend outside** every day?

☐Less than1 hour ☐1-3 hours ☐More than 3 hours

32. About how many hours are **spent reading** with your child every day?

☐Less than 15 minutes ☐15-30 minutes ☐30 minutes to1 hour ☐More than 1 hour

33. Does your child **wear a helmet** when riding a bike, roller blading, skate boarding, etc?

☐Yes ☐No ☐Does not do activities like that

34. Does your child get **buckled in a car seat** or **wear a seat belt** when riding in a car? ☐Yes ☐ No

35. Do you have **guns** in the home? Yes ☐ No ☐

If yes, are they **locked up**? Yes ☐ No ☐

36. What **activities** is your child involved in:

☐Riding bike ☐T-ball/baseball ☐Dance/movement ☐Skate boarding
☐Karate ☐Video games ☐Girl Scouts/Boy Scouts
☐Soccer ☐Playing a musical instrument
☐Reading ☐Playing with friends
☐Other team sports _____
☐Other activity(s) _____
☐Too young to be involved in activities

37. Please list what your child typically **eats and drinks in a day** for:

Breakfast_____

Lunch_____

Dinner _____

Snacks _____

FAMILY

38. Check all the people that the **child lives with**:

☐Mother

☐Father

☐Brothers (how many?_____)

☐Sisters (how many? _____)

☐Other family members (list _____)

☐Friends or other people (list_____)

☐Animals ☐Dogs (how many?_____) ☐Cats (how many? _____)

☐Other animals _____

39. What medical problems do people in the child's family have?

Family Member	Medical Problems
Mother:	☐Depression ☐Anxiety (nerve) problems ☐Learning disability ☐Overweight ☐High blood pressure ☐Diabetes (sugar) ☐Cancer ☐Heart problems ☐Other: _____
Father:	☐Depression ☐Anxiety (nerve) problems ☐Learning disability ☐Overweight ☐High blood pressure ☐Diabetes (sugar) ☐Cancer ☐Heart problems ☐Other: _____
Sisters:	☐Depression ☐Anxiety (nerve) problems ☐Learning disability ☐Overweight ☐High blood pressure ☐Diabetes (sugar) ☐Cancer ☐Heart problems ☐Other: _____
Brothers:	☐Depression ☐Anxiety (nerve) problems ☐Learning disability ☐Overweight ☐High blood pressure ☐Diabetes (sugar) ☐Cancer ☐Heart problems ☐Other: _____