Mankato Clinic

Health History

New Child or Adolescent Checkup or Illness

Interpreter Present: _______ Yes _______ No

Name: ____

Language: ____

Brought into Clinic by: _________________________

Reason for visit: ________________________________

List any questions or concerns you have about your child

____

____

____

PAST HEALTH HISTORY

A. Pregnancy and birth

1. Did mother have any illness/ problems during pregnancy with this child? ☐Yes ☐No
2. Was this child born prematurely? ☐Yes ☐No
3. Mother's weight gain? _________
4. During the pregnancy, did mother use:
   - Cigarettes? ☐Yes ☐No
     How much? ___________________________
   - Alcohol? ☐Yes ☐No
     How much? ___________________________
   - Street drugs? ☐Yes ☐No
     How much? ___________________________
5. Type of birth? ☐Vaginal ☐Cesarean
6. Any problems during labor or delivery? ☐Yes ☐No If yes, please explain: ______________

   ____

   ____

   ____
7. Baby's birth weight: _______________________
8. Did baby / mother have any problems when in hospital? ☐Yes ☐No If yes, please explain:

   ____

   ____

   ____
9. Did your child require any Special tests? ☐Yes ☐No If yes, please explain: ___________

   ____

   ____

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MC536 (07/14)

Has your child ever had any of the following? If yes, please list what they had and when it occurred:

		Yes	No
10.	Allergic reaction to:		
	• Medications? __________________	☐	☐
	• Foods? __________________	☐	☐
	• Insect bites? __________________	☐	☐
	• Immunizations (shots)? ____________	☐	☐
11.	Hospitalizations? __________________	☐	☐
12.	Surgery? __________________	☐	☐
13.	Serious injuries or accidents? __________________	☐	☐
14.	Frequent colds? __________________	☐	☐
15.	Frequent ear infections? ______________	☐	☐

Please check (✓) if your child has or ever had any of the following conditions:

- ☐ Anemia (low-iron in blood)
- ☐ Fainting episodes
- ☐ Asthma
- ☐ Frequent respiratory infections
- ☐ Bladder/Kidney infection
- ☐ Meningitis
- ☐ Broken Bones
- ☐ Pneumonia
- ☐ Chickenpox
- ☐ Seizures
- ☐ Diabetes
- ☐ Strep infections/ Scarlet fever
- ☐ Ear infections
- ☐ Sinus infections
- ☐ Hay fever/Allergies
- ☐ None
- ☐ Head injuries

16. Has your child required any special tests? ☐Yes☐No
    Please explain ______________________________

    ____

    ____
17. Please list any information about your child that you feel we should know: ___________________

    ____

    ____

    ____

    ____

B. Family History

☐ Child is Adopted – Family history unknown
☐ Parent is Adopted – Family history unknown

1. Are parents both in good health? ☐Yes ☐No
2. **Check (✓)** any health conditions **your child's parents, grandparents, brothers, sisters, aunts, or uncles** have had and indicate which family member by writing behind the condition.

- ☐ Alcohol or drug problems ________
- ☐ Allergy / Hay fever ________
- ☐ Asthma ________
- ☐ Birth defects ________
- ☐ Bleeding disorders ________
- ☐ Blood clots ________
- ☐ Cancer ________
  - Breast ________
  - Ovarian ________
  - Uterine ________
  - Prostate ________
- ☐ Diabetes ________
- ☐ Ear infections ________
- ☐ Eczema/Psoriasis ________
- ☐ Epilepsy/Seizures ________
- ☐ Gallbladder disease ________
- ☐ Hearing problems/Deafness ________
- ☐ Heart murmur ________
- ☐ Heart problems Heart attacks ________
- ☐ High blood pressure ________
- ☐ High cholesterol ________
- ☐ Kidney problems/Bladder infections________
- ☐ Learning problems ________
  - ADD/ADHD ________
  - Reading problems ________
  - Mental retardation ________
- ☐ Liver problems ________
- ☐ Mental illness ________
  - Depression ________
  - Schizophrenia ________
  - Bipolar ________
- ☐ Migraine headaches ________
- ☐ Obesity (overweight) ________
- ☐ Scoliosis (curvature of the spine) ________
- ☐ Sinus problems ________
- ☐ Stroke ________
- ☐ Sudden deaths during exercise ________
- ☐ Thyroid problems ________
- ☐ Tuberculosis ________
- ☐ Ulcers ________
- ☐ Vision problems:
  - Cataracts ________
  - Glaucoma ________
  - Lazy Eye ________

☐ List any other illnesses that run in your family :

____
____
____

C. Review of Systems

Please check (✓) if your child has any of the following:

☐Birthmarks/Moles	☐High blood pressure
☐Blurry vision/ difficulty seeing /double vision	☐Hoarse sounding voice
☐Bruises easily	☐Joint pain/stiffness/ swelling
☐Chest pain with exercise	☐Leg pain
☐Crossed eyes	☐Limp
☐Difficulty breathing	☐Loss of balance sometimes
☐Difficulty Hearing / Hearing loss	☐Loss of eyesight
☐Difficulty swallowing	☐Mattery eyes
☐Dizziness	☐Nausea / Vomiting
☐Drainage from or pain in ears	☐Poor activity level/ get tired easily
☐Dry skin	☐Rashes
☐Frequent bloody nose	☐Red eyes
☐Frequent cough	☐Ringing in ears
☐Frequent runny / stuffy nose	☐Scoliosis (crooked spine)
☐Frequent sore throat	☐Stomach cramps/pain
☐Headaches	☐Warts
☐Heart murmur	☐Wheeze or cough during/after exercise
☐Other ________	☐None

Reviewed by ________________________________
(Medical Provider's signature)