First Choice Health Centers
For All Your Health Care Needs

SCHOOL BASED HEALTH CARE PEDIATRIC PATIENT HISTORY

SBHC: ☐ New Patient ☐ Established Patient Today's Date: _____

Parent(s) Name: _____

Child's Full Name: _____ Date of birth: _____ Gender ☐ M ☐ F

Child's Doctor: _____

Child's Medical History ☐ Unknown ☐ No Significant Medical History

Complete below section if child is less than 5 years old or if there was a significant/complicated pregnancy history

Pregnancy/Birth History: *Check all that apply*

Month prenatal care began _____
Weeks of pregnancy _____
Birth Weight _____ ☐ C-Section ☐ Vaginal

Pregnancy Complications:
☐ Infections ☐ Diabetes ☐ Pre-eclampsia
☐ Multiple Births _____
☐ Other _____

Birth/Newborn Complications:
☐ Premature? – How early? _____
☐ NICU stay? – How long? _____
☐ Other _____

Medications: _____

During pregnancy, the child's mother:
☐ Smoked - How much? _____
☐ Drank alcohol - How much? _____

DENTAL APPOINTMENTS ONLY: Fill in only highlighted sections below.

Current Medications:

Allergies to Medicines: **Reaction:**

This Child has been DIAGNOSED with:

☐ ADD/ADHD Age:_____
☐ Allergies/Hay fever Age:_____
☐ Anemia Age:_____
☐ Asthma Age:_____
☐ Autism Age:_____
☐ Bipolar Disorder Age:_____
☐ Bleeding/Blood Disorder Age:_____
☐ Broken Bones - Detail below _____ Age:_____
☐ Cancer - Type: _____ Age:_____
☐ Celiac Disease Age:_____
☐ Chicken Pox Age:_____
☐ Constipation Age:_____
☐ Depression Age:_____
☐ Developmental Delay Age:_____
☐ Diabetes Age:_____
☐ Frequent Ear Infections Age:_____
☐ Stomach/Bowel Disorder Age:_____
☐ Headaches/migraines Age:_____
☐ Heart Conditions Age:_____
☐ Infectious Diseases Age:_____
☐ Learning Disabilty Age:_____
☐ Pneumonia Age:_____
☐ Scoliosis (curved spine) Age:_____
☐ Seizures/epilepsy Age:_____
☐ Sickle Cell Anemia Age:_____
☐ Stomach Problems Age:_____
☐ Skin Issues Age:_____
☐ UTI/Bladder Infections Age:_____
☐ Other: _____ Age:_____

Child's SURGERIES ☐ None

☐ Appendectomy Age:_____
☐ Adenoidectomy Age:_____
☐ Ear Tubes Age:_____
☐ Other _____ Age:_____
☐ Other _____ Age:_____
☐ Eye Surgery Age:_____
☐ Hernia repair Age:_____
☐ Tonsillectomy Age:_____

Child's Hospitalizations:
Hospitalization: _____ Age:_____
Hospitalization: _____ Age:_____
Hospitalization: _____ Age:_____

Child's Family History: Check the diagnoses given to the child's relatives. ☐ **Unknown**

Please circle relationship:

M=Mother, F=Father, S=Sibling(s), GM = Grandmother, GF=Grandfather, O=Other Relative(s)

Diagnosis of relative:	Relationship to child	Diagnosis of relative:	Relationship to child
☐ ADD	M F S GM GF O	☐ High Blood Pressure	M F S GM GF O
☐ Allergies	M F S GM GF O	☐ High Cholesterol	M F S GM GF O
☐ Anemia	M F S GM GF O	☐ Learning Disability	M F S GM GF O
☐ Asthma	M F S GM GF O	☐ Mental retardation	M F S GM GF O
☐ Autism	M F S GM GF O	☐ Psychiatric Illness (Depression, addiction, etc)	M F S GM GF O
☐ Blood Disorder/ Sickle Cell	M F S GM GF O	☐ Seizures/epilepsy	M F S GM GF O
☐ Cancer	M F S GM GF O	☐ SIDS (crib death)	M F S GM GF O
☐ Celiac Disease	M F S GM GF O	☐ Stroke before age 55	M F S GM GF O
☐ Diabetes	M F S GM GF O	☐ Sudden Death before age 50	M F S GM GF O
☐ Stomach/Bowel Disorder	M F S GM GF O	☐ Other _____	M F S GM GF O
☐ Heart disease before age 55	M F S GM GF O		

Social/Environmental

Child lives w/:
☐ Parent(s): ☐ Together ☐ Apart
☐ Mother
☐ Father
☐ Relative _____
☐ Other _____

Adopted ☐
Smokers live in home with child? ☐ Yes ☐ No
Child attends day care? ☐ Yes ☐ No
Pets in the home? ☐ Yes ☐ No
Well water? ☐ Yes ☐ No
Home built before 1960? ☐ Yes ☐ No

Other _____