LINN COMMUNITY Care
COMMUNITY HEALTH CENTER

CHILDRENS MEDICAL HISTORY
(AGES 0 TO 17)

Date filled out _____
Age when filled out_____

Child's Name_____Filled out by_____Relationship_____
Sex: M_____ F_____ Birthdate_____ Birthplace_____

PERSONAL DATA

Please list:

	Name	Age	Health
Father			
Mother			
Brothers/			
Sisters			

Others living at home:

Name	Age	Relationship

Does the child or any blood relative have:

	Child Yes	Child No	Relative Yes	Relative No
Heart disease				
High blood pressure				
Diabetes				
Cancer				
Kidney disease				
Asthma/Allergies				

	Child Yes	Child No	Relative Yes	Relative No
High cholesterol				
Convulsions				
Emotional problems				
Learning or speech problems				
Other family problems				

DEVELOPMENT (for preschoolers)

Age at which baby: held head steady _____ sat alone _____ crawled _____
had first words _____ walked _____ toilet trained _____
Do you think your child's development is normal? Yes____ No_____
If no, Why? _____

HEALTH

General health: good____ fair____ poor____
Allergies (list drugs, food, reactions, etc.):_____
_____
Medications in the past year _____
Past injuries or fractures _____
Hospitalizations _____
_____
Immunizations: (date) _____
DPT (series of 3) _____ _____ _____
Booster _____ _____
Polio (series of 3) _____ _____ _____
Booster _____ _____
TB test_____ Measles _____ Mumps _____ Rubella _____

Has child had:	Yes	No
feeding or appetite problems.....		
urinary infections		
bedwetting		
many ear infections.....		
other_____		
_____		
Sees a dentist once a year		
last visit		
If under 5 years, uses a car safety/belt...		

SOCIAL/SCHOOL ADJUSTMENT

Happy Child _____ Fussy _____ Hard to manage _____ Short attention span _____ Overactive _____
Plays with others: Nicely _____ With some squabbles _____ Poorly _____
Temper tantrums _____ Attended preschool _____ Current grade _____ School_____
School work: Good _____ Average _____ Poor _____ Special play interests/hobbies _____

LIST OTHER PHYSICIANS CHILD HAS SEEN: