This is a fillable PDF form. For full functionality, please download the form and use **Adobe Acrobat Reader** to complete it, save it, then email it to **staff@epitomedical.com** or simply print it out and complete it by hand. This notice will not print.

EPITOMEDICAL.

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CHILD HEALTH HISTORY FORM

BIRTH HISTORY

Patient Name: _____ Age: _____ Today's Date: _____

Birth Weight: _____ Length: _____ Location: _____

During the pregnancy, did the mother see a doctor on a regular basis? ☐ Yes ☐ No

During the pregnancy did the mother: If yes, please explain:

Have any medical problems?	☐ Yes	☐ No	_____
Have a venereal disease?	☐ Yes	☐ No	_____
Smoke Tobacco?	☐ Yes	☐ No	_____
Have hepatitis?	☐ Yes	☐ No	_____
Use any medications?	☐ Yes	☐ No	_____
Use alcohol or other drugs?	☐ Yes	☐ No	_____
Have problems with labor/delivery?	☐ Yes	☐ No	_____

Type of delivery ☐ Vaginal ☐ C-Section

How long did the baby stay in the hospital after birth? _____

CHILD'S PAST MEDICAL HISTORY

How would you describe the child's health? ☐ Good ☐ Fair ☐ Bad

Please list:

Does the child have any allergies? ☐ Yes ☐ No _____

Is the child taking any medications? ☐ Yes ☐ No _____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____ Date: _____

_____ Date: _____

Who takes care of the child? _____

HOUSEHOLD INFORMATION

Please list all people in household:

	Name:	Age:
Father:	_____	_____
Mother:	_____	_____
Other:	_____	_____
Other:	_____	_____
Other:	_____	_____
Other:	_____	_____

FAMILY HISTORY

Have any of the child's brothers or sisters died? ☐ Yes ☐ No

If yes, give age at death and cause: _____

Have any of the child's blood relatives had the following diseases? (If yes, list family member and age of onset)

			Family Member:				Family Member:
Heart Disease	☐ Yes	☐ No	_____	Cancer	☐ Yes	☐ No	_____
Tuberculosis	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____	Mental / Emotional Problems	☐ Yes	☐ No	_____
Kidney Disease	☐ Yes	☐ No	_____	Sickle Cell Disease	☐ Yes	☐ No	_____
Allergies	☐ Yes	☐ No	_____	Seizures	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____	Other (please list):	_____		

Reviewed by Physician: _____ Date: _____