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EPSDT HEALTH HISTORY

Name ____

Sex M ___ F ___ Race ______________ SSN ____________ DOB ______________

Please list all people in household:

Name	Date of birth	Occupation	Education
Father			
Mother			
Other			
Other			
Other			
Other			

Have there been any major changes or stresses in the child's life? Yes ____ No ____

If YES, explain: ____

Does child go to a baby sitter, preschool or day care regularly? Yes ____ No ____

BIRTH HISTORY

Birth weight ____________ Length ______________ Place ______________________

During the pregnancy, did the mother see a doctor regularly? Yes ____ No____

During the pregnancy, did the mother (If YES, explain)

- Have any medical problems? Yes ____ No ____ ______________________
- Smoke or drink? Yes ____ No ____ ______________________
- Use any medications? Yes ____ No ____ ______________________
- Use alcohol or drugs? Yes ____ No ____ ______________________
- Have problems with labor/delivery? Yes ____ No ____ ______________________

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

PAST MEDICAL HISTORY

Is the child's general health (check one) Good ______ Fair ______ Poor ______

Explanation: ____

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 __________

____ Date __________

Has the child ever had any problems with the following? If YES, please explain:

Eyes/Vision	Yes ____	No ____	______________________
Feet	Yes ____	No ____	______________________

Digestion/Nutrition	Yes ____	No ____	________________
Ears/Hearing	Yes ____	No ____	________________
Urine/Kidneys	Yes ____	No ____	________________
Joints	Yes ____	No ____	________________
Skin	Yes ____	No ____	________________
Lungs	Yes ____	No ____	________________
Teeth	Yes ____	No ____	________________
Heart	Yes ____	No ____	________________
Seizures	Yes ____	No ____	________________
Repeated Infections	Yes ____	No ____	________________

FAMILY HISTORY

Have any of the child's brothers or sisters died? Yes ____ No ____
If YES, give age and cause: ________________

Have any of the child's blood relatives had the following diseases? If YES, please list family member:

Heart Disease	Yes ____	No ____	________________
Tuberculosis	Yes ____	No ____	________________
High Blood Pressure	Yes ____	No ____	________________
Kidney Disease	Yes ____	No ____	________________
Allergies/Asthma	Yes ____	No ____	________________
Cancer	Yes ____	No ____	________________
Diabetes	Yes ____	No ____	________________
Mental/Emotional Problems	Yes ____	No ____	________________
Sickle Cell	Yes ____	No ____	________________
Seizures	Yes ____	No ____	________________

DEVELOPMENT

Do you have any concerns about the following? If YES, please explain:

Development	Yes ____	No ____	________________
Behavior	Yes ____	No ____	________________
Eating Habits	Yes ____	No ____	________________
Sleeping Habits	Yes ____	No ____	________________
School Experience	Yes ____	No ____	________________
Bathroom/Toilet Habits	Yes ____	No ____	________________
Discipline	Yes ____	No ____	________________
Other (explain)	Yes ____	No ____	________________

IMMUNIZATIONS

Name________ Date_____ Date_____ Date_____ Date_____ Date_____ Reactions________________
DTP________________
TOPV________________
MMR________________
TB (test) ________________
____
____

Reviewed by:________________ Date:________________