Dr. Rachel Rubin-Toles, M.D. 7366 N. La Cholla Blvd. Tucson, AZ 85741

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## **EPSDT HEALTH HISTORY**

ather Mother	Sex M F Rac	xe S	SN	DOB
Name Date of birth Occupation Education rather Mother Other				
Tather Mother	riease list all people ill no	ousenota:		
Mother	Name	Date of birth	Occupation	Education
Mother	Father			
Dither Diving the presentation of the place Diving the pregnancy, did the mother see a doctor regularly? Yes No_Diving the pregnancy, did the mother (If YES, explain) Have any medical problems? Yes No Smoke or drink? Yes No_Diving the pregnancy, did the mother (If YES, explain) Have any medical problems? Yes No_Diving the pregnancy did the mother (If YES, explain) Have any medications? Yes No_Diving the pregnancy did the baby stay in the hospital after birth? Diving did the baby stay in the hospital after birth?  PAST MEDICAL HISTORY  Is the child's general health (check one) Good Fair Poor Poor Explanation:  Does the child have any allergies? Yes No_District State of the child have any allergies? Yes No_District State of the child have any allergies? Yes No_District State Date Date Date Date Date Date Date	Mother			
Dither Di	Otner			
Have there been any major changes or stresses in the child's life? Yes No  If YES, explain:	Other			
Have there been any major changes or stresses in the child's life? Yes No  If YES, explain:	Other			
Have there been any major changes or stresses in the child's life? Yes No  If YES, explain:	Other			
Does child go to a baby sitter, preschool or day care regularly? Yes No  BIRTH HISTORY  BIRTH HISTORY  BIRTH HISTORY  BIRTH HISTORY  BIRTH Weight				
Does child go to a baby sitter, preschool or day care regularly? Yes No  BIRTH HISTORY  Birth weight Length	nave there seen any maje	or changes of stresses in th	c cinia s inc. Tes_	
Does child go to a baby sitter, preschool or day care regularly? Yes No  BIRTH HISTORY  Birth weight Length	If YES, explain:	400		
BIRTH HISTORY  Birth weight Length Place				
BIRTH HISTORY  Birth weight Length Place				
BIRTH HISTORY  Birth weight Length Place	Does child go to a baby si	itter, preschool or day care	regularly? Yes	No
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 Have problems with labor/delivery? 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 Date  Date Date Date Date Date	BIRTH HISTORY			
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Explanation:	Is the child's general heal	th (check one) Good	Fair Poor	
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Please list any hospitalizations, operations, serious illnesses or accidents with dates:  Date Date Date Date Date Date Date Date Date	Does the child have any a	llergies? Yes N	Jo.	
Please list any hospitalizations, operations, serious illnesses or accidents with dates:    Date	Is the child taking any me	edications? Yes N	Jo	
Date	is the office taking they me	1051		
Date	Please list any hospitaliza	tions, operations, serious	illnesses or accidents v	vith dates:
Date Date Date Date Date Date Date Date	. read not any mospituitze	mone, operations, serious		Date
Date  Has the child ever had any problems with the following? If YES, please explain:  Eyes/Vision Yes No				Date
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Eyes/Vision Yes No				
Eyes/Vision Yes No				
Eyes/Vision Yes No				
Eyes/Vision Yes No				
Eyes/Vision Yes No				
	Has the child ever had an	y problems with the follow	ving? If YES, please e	explain:
	Evec/Vicion	Vac Na		
	Eyes/ vision Feet	transmission of the second second second		

Digestion/Nutrition	Yes	No				
Ears/Hearing	Yes	No				
Urine/Kidneys						
Joints	Yes	No				
Skin					Very	
Lungs	Yes_	No				•
Teeth	Ves	No				
Heart	Yes _	No				
Seizures	Vec	No				
Repeated Infections	Yes_	No_				
FAMILY HISTORY						
	1		0 17	21		
Have any of the child's brot	hers or s	sisters died	? Yes_	No		
If YES, give age and cause:		-				
Have any of the child's bloc	od relativ	ves had the	following	g diseases?	If YES, please list famil	y 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 T	No				
Sickle Cell	Yes	No				1361365
Seizures	Yes _	No				
DEVELOPMENT						
Do you have any concerns a	about the	e following	? If YES,	, please exp	lain:	
Development	Vec	No				
Behavior	Yes _	No				
Eating Habits	Yes_	No	-			
Sleeping Habits	Yes_					
School Experience	Voc		-			
Bathroom/Toilet Habits	Yes					
Discipline Discipline	Yes_	No				
Other (explain)	Yes_	No No	-			
IMMUNIZATIONS						
	Date	Date	Date	Date	Reactions	
DTP						
TOPV						
MMR_						
TB (test)						
Reviewed by:				D-4		
Reviewed by.				Date:		