

## ConnextCare <u>Child</u> Health History Form

| DOB: Sex: M F   MEDICAL HISTORY:   Birth Wt: Length: Place of Birth:   Does the child have any serious medical problems? If yes please list:   Does the child have any serious medical problems? If yes please list:   FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis:   HOSPITALIZATIONS/SURGERY:   DATE:   CONDITION/SURGERY:   NONE:   DATE: | Name:   |                    |       | Date:           |  |
|--|---|--------------------|-------|-----------------|--|
| Birth Wt.: Length:   Does the child have any serious medical problems? If yes please list:   FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis:   HOSPITALIZATIONS/SURGERY:   NONE:  | DOB:  | Sex:               | М     | F               |  |
| Does the child have any serious medical problems? If yes please list:         FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis:         HOSPITALIZATIONS/SURGERY:   | MEDICAL HISTORY:  |                    |       |                 |  |
| FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis:         HOSPITALIZATIONS/SURGERY:   | Birth Wt.:  | Length:            |       | Place of Birth: |  |
| cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:   | Does the child have any serious medical problems? If yes please list: |                    |       |                 |  |
| cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:   |   |                    |       |                 |  |
| cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:   |   |                    |       |                 |  |
| HOSPITALIZATIONS/SURGERY: NONE:  |   |                    |       |                 |  |
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| DATE: CONDITION/SURGERY:   | HOSPITALIZATIONS/SURGERY: NO  |                    | NONE: |                 |  |
|  | DATE:   | CONDITION/SURGERY: |       |                 |  |
|  |   |                    |       |                 |  |
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| SOCIAL HISTORY:  |   |                    |       |                 |  |
| Number of Adults at Home: Number of Children at Home:  |   |                    |       |                 |  |
| Any Smokers Living in the Home?  |   |                    |       |                 |  |
| Current School:  |   |                    |       |                 |  |
| Does the child have records at an additional Physician/Pediatrician's office? Yes / No   |   |                    |       |                 |  |
| If yes please list name and address:   |   |                    |       |                 |  |