ConnextCare
Child Health History Form

Name:_____ Date:_____

DOB: _____ Sex: M F

MEDICAL HISTORY:

Birth Wt.:_____ Length:_____ Place of Birth: _____

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:**
DATE:	CONDITION/SURGERY:	

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: _____