HEALTHCHECK INDIVIDUAL HEALTH HISTORY

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Fill out one form for each person screened | | | | | Current Member I.D. Number Per Code | | | | |
| Date Completed (Month / Day / Year) | | | | |
| Name – Patient | | | | | Name - Parent or Guardian | | | | |
| Address – Patient | | | | | Address – Parent or Guardian | | | | |
| Telephone – Patient | | | | | Telephone – Parent or Guardian | | | | |
| Birth Date – Patient (Month / Day / Year) | | | | |  | | | | |
| School and Grade or Occupation – Patient | | | | |  | | | | |
| Name and Address – Physician | | | | | | | | | |
| Name and Address – Dentist | | | | | | | | | |
| **GENERAL HEALTH -** Answer for All Ages | | | | | | | | | |
| **Office Use** | Yes | **No** | **Don’t Know** |  | | | | | |
| 1 |  |  |  | Has it been more than 12 months since this person had a general checkup by a physician? | | | | | |
| 2 |  |  |  | Has it been more than 12 months since a physician examined this person because of illness or injury? | | | | | |
| 3 |  |  |  | Has it been more than 12 months since this person had a general checkup by a dentist? | | | | | |
| 4 |  |  |  | Has it been more than 12 months since a dentist examined this person because of illness or injury? | | | | | |
| 5 |  |  |  | Is there anything about this person’s health, growth or development that you are concerned or worried about? If YES, explain. | | | | | |
| 6 |  |  |  | Does this person always use a seatbelt or car seat in an automobile? | | | | | |
| DID THIS PERSON EVER HAVE OR DOES THIS PERSON NOW HAVE ANY OF THE FOLLOWING? | | | | | | | | | |
| **Office Use** | Yes | **No** | **Don’t Know** |  | **Office Use** | **Yes** | **No** | **Don’t Know** |  |
| 7 |  |  |  | Unexplained fever | 20 |  |  |  | Vomiting or diarrhea |
| 8 |  |  |  | Poor appetite or feeding problem | 21 |  |  |  | Wheezing or noisy breathing |
| 9 |  |  |  | Loss of weight | 22 |  |  |  | Swollen joints |
| 10 |  |  |  | Loss of consciousness, fainting | 23 |  |  |  | Heart murmur |
| 11 |  |  |  | Head injury | 24 |  |  |  | Frequent stomach aches |
| 12 |  |  |  | Seizure, convulsions, fits | 25 |  |  |  | Blood in bowel movements |
| 13 |  |  |  | Frequent headache | 26 |  |  |  | Bladder, kidney, or urinary problems |
| 14 |  |  |  | Eye trouble | 27 |  |  |  | Blood in urine |
| 15 |  |  |  | Earaches, draining ears | 28 |  |  |  | Rashes, eczema, hives, skin problems |
| 16 |  |  |  | Frequent nosebleeds | 29 |  |  |  | Many bruises or bleedings |
| 17 |  |  |  | Chronic cough | 30 |  |  |  | Frequent stumbling, falling |
| 18 |  |  |  | Hearing problems | 31 |  |  |  | Frequent colds or infections |
| 19 |  |  |  | Constipation |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Office Use** | **Yes** | **No** | **Don’t  Know** | **HAS THIS PERSON HAD ANY OF THE FOLLOWING?** |
| 32 |  |  |  |
|  |  |  |  | Rubella (German measles) |
|  |  |  |  | Measles (Red) |
|  |  |  |  | Mumps |
|  |  |  |  | Rheumatic Fever |
| 33 |  |  |  | Did or does this person have allergies? If YES, describe. |
| 34 |  |  |  | Did or does this person have asthma? |
| 35 |  |  |  | Has this person had any serious accidents? If YES, describe. |
| 36 |  |  |  | Has this person had any hospitalizations, operations, major illness? If YES, describe. |
| 37 |  |  |  | Does this person now have any problems which you feel, or which a physician has told you, may be related to any one of the conditions 7 – 36? If YES, describe. |
| 38 |  |  |  | Does this person OFTEN eat things which are not usually considered to be food? (Example: dirt, paint chips, crayons, clay, starch, newspaper.) If YES, describe. |
| 39 |  |  |  | Does this person have problems with toileting or toilet training? |
| 40 |  |  |  | Does this person get along with family members and playmates? |
| 41 |  |  |  | Does this person have difficulty learning? |
| 42 |  |  |  | Does this person get into trouble in school or dislike school? |
| 43 |  |  |  | Has this person taken prescription medicines in the last 12 months? For what? |
| 44 |  |  |  | Has this person taken non-prescription medicines in the last 12 months? (Example: aspirin, antihistamines, vitamins, food supplements.) If so, what medications? |
| 45 |  |  |  | Has this person ever had a positive reaction to a tuberculosis test? |
| 46 |  |  |  | Referred for Adolescent Review. |
| 47 |  |  |  | ANSWER FOR FEMALES BORN BEFORE 1972: Did the mother of this person take any medications to prevent miscarriage during this pregnancy? |

**IMMUNIZATION HISTORY: List the immunizations and dates (month/date/year) received.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Vaccine** | **Dose 1** | **Dose 2** | **Dose 3** | **Dose 4** | **Dose 5** |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

**BEHAVIORAL / EMOTIONAL HEALTH**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Office Use** | **Yes** | **No** | **Don’t  Know** |  |
| 48 |  |  |  | Does this person have a history of either:   * Behavioral or emotional problems OR * Treatment for behavior or emotional problems at a clinic or hospital?   If YES for any, explain. |
| 49 |  |  |  | Has anyone in this person’s family ever been treated or hospitalized for emotional problems such as depression, anxiety, mood swings, suicide attempts, or alcohol or drug abuse? If YES for any, explain. |
| 50 |  |  |  | Has this person ever abused alcohol and/or drugs? If YES, explain. |
| 51 | Has this person ever  felt hopeless or depressed  had an excess of energy or activity  had unexplained crying spells  felt like hurting him/her self  planned or attempted suicide  displayed reckless or dangerous behavior  had peculiar or bizarre thoughts  heard things no one else around them heard  had trouble eating or sleeping  show inappropriate emotions  (too much or too little) (reactions that don’t make sense for the situation) | | | |
| 52 | Does this person have any of these problems at school?  poor grades  fighting or arguing with peers or teachers  difficulty in making friends  frequently lying or stealing  frequent suspensions from schools  frequently cutting classes or playing hooky | | | |
| 53 | Has this person had any of the following problems at home or in the community?  withdrawing socially (doesn’t want  clinging excessively to a parent, teacher, or other person  to be around other people)  running away from home  lying or stealing  problems with police  arguing or fighting with peers or  refusing to follow instructions from parents,  brothers or sisters or obey the house rules, etc. | | | |

Criteria for Referral for Further Assessment

48. and 50. Refer for a psychiatric assessment if there is a positive response.

49. Refer only if referred criteria are met for any other question.

1. Refer for a psychiatric assessment if any responses are checked.

52. and 53 Refer for a psychiatric assessment if two or more responses are checked.

**PREGNANCY & DEVELOPMENT**

Answer for all Ages

BIRTH ORDER of this person. Indicate by placing a check mark in the appropriate box whether this person was the first, second, etc. Do not count stillborn brothers or sisters.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1st | | 2nd | | 3rd | | 4th | 5th | 6th | 7th | 8th | 9th | 10th or over |
| MOTHER’S AGE AT THIS BIRTH | | | | | | Check one | Under 17 | | 17-39 | 40 and over | | Unknown |
| FATHER’S AGE AT THIS BIRTH | | | | | | Check one | Under 17 | | 17-39 | 40 and over | | Unknown |
| 54 | Yes | | **No** | | **Don’t Know** | **MOTHER’S PREGNANCY HISTORY-**Answer only for children UNDER 6 YEARS | | | | | | |
|  |  | |  | |  | Was there any bleeding during this pregnancy? | | | | | | |
|  |  | |  | |  | Was the baby born early? If so, how many weeks? | | | | | | |
|  |  | |  | |  | Was there other difficulty or illness during this pregnancy? (Examples: rubella or german measles, high blood pressure, high blood sugar, sexually transmitted diseases.) If YES, describe. | | | | | | |
|  |  | |  | |  | Were any x-rays taken during pregnancy? | | | | | | |
|  |  | |  | |  | Were any prescription or other drugs taken during pregnancy? (Examples: tranquilizers, antibiotics, sedatives, medicines for vomiting, medicines – shot or oral – to prevent miscarriage or bleeding.) If YES, describe. | | | | | | |
|  |  | |  | |  | Were any non-prescription medications taken during pregnancy? (Examples: vitamins, iron supplements, frequent aspirin.) If YES, describe. | | | | | | |
|  |  | |  | |  | Was there anything unusual about the labor or delivery? If YES, describe. | | | | | | |
| 55 |  | |  | |  | **DEVELOPMENTAL MILESTONES-**Answer only for children UNDER 6 YEARS | | | | | | |

Birth Weight:      lbs.       ozs. Length       inches

Check the appropriate time this child did each of the following.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Follow object with eyes | Roll over | Turn to voice | Sit alone | Act shy with strangers |
| Not yet | Not yet | Not yet | Not yet | Not yet |
| Before 1 month | Before 2 months | Before 3 months | Before 5 months | Before 5 months |
| 1 - 4 months | 2 - 5 months | 3 - 8 months | 5 - 9 months | 5 - 10 months |
| After 4 months | After 5 months | After 8 months | After 9 months | After 10 months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Walk alone | Speak single word | **Speak simple sentences** | Eat finger food alone | Use cup alone |
| Not yet | Not yet | Not yet | Not yet | Not yet |
| Before 11 months | Before 9 months | Before 20 months | Before 2 years | Before 2 years |
| 11 - 15 months | 9 - 12 months | 20 mo. - 2 ½ years | After 2 years | After 2 years |
| After 15 months | After 12 months | After 2 ½ years |  |  |

Permission is hereby granted for health screening for early detection of health problems for

**and for the release of resulting information to appropriate health care providers and health authorities. Permission is also granted to such health care providers and health authorities to release information to personnel conducting this health-screening program.**

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**SIGNATURE** Relationship to PatientDate Signed