McLane Children's Hospital
SCOTT&WHITE

CHILD HEALTH RECORD
CHILD MEDICAL HISTORY FORM

Patient Identification

Can you read and write English? ☐ Yes ☐ No
Do you need help completing this form? ☐ Yes ☐ No

I. ENVIRONMENTAL HISTORY

☐ City Water ☐ Well Water ☐ Bottled Water
☐ Day Care ☐ Household pets ☐ Unusual Toxins or Chemicals
☐ Tobacco Smoke in Home ☐ Recent Travel

II. SOCIAL HISTORY

Patient's age: _____ Sex: _____ Grade: _____
Father: ☐ Married ☐ Divorced ☐ Separated ☐ Remarried
Father's age: _____ Father's Occupation: _____ Last Grade Completed: _____
Mother: ☐ Married ☐ Divorced ☐ Separated ☐ Remarried
Mother's age: _____ Mother's Occupation: _____ Last Grade Completed: _____
Brother's ages: _____ Sister's ages: _____
Who is the primary caregiver at home? _____
Has there been any recent family stress or social change? _____

III. CHILD'S MEDICAL HISTORY

Immunizations Current: ☐ Yes ☐ No Record Available: ☐ Yes ☐ No

Please explain any problems of the child in the following areas:

☐ Asthma ☐ Ear Infections ☐ Cerebral Palsy
☐ Bladder/Kidney Infection ☐ Diabetes ☐ Seizure(s)
☐ Developmental Delay ☐ Learning Disorder ☐ Blood Transfusion
☐ Allergies _____ ☐ Hearing/Vision Problems _____
☐ Hospitalizations/Operations _____
☐ Injuries _____ ☐ Major Illnesses _____
☐ School Problems _____ ☐ Behavioral Problems _____
☐ Herbal medication or over the counter medications _____
☐ Alternative healthcare _____
☐ Chiropractic ☐ Acupuncture ☐ Acute/Chroinc Pain _____

List current medications: _____
Are you interested in learning more about your child's health condition? Yes____ No____

IV. DISEASES IN FAMILY - Relationship to Patient

Drug Abuse _____ Heart disease before age 50 _____
Alcohol Abuse _____ Hearing Problems _____
Tobacco Abuse _____ High blood pressure _____
Domestic Violence _____ Stroke _____

CHILD HEALTH RECORD
CHILD MEDICAL HISTORY FORM

Patient Identification

Epilepsy/Seizures _____ Diabetes _____
Allergies _____ Asthma _____
Birth Defects _____ Cancer _____
Kidney Problems _____ Learning Disorders _____
Mental Illness _____ Any rare or inherited disease _____

V. BIRTH HISTORY (if under the age of 5 years)

☐ Maternal complications ☐ Maternal substance abuse
If yes, explain:

Birth weight: _____ Birth Length: _____

Any problems: _____

☐ Patient is adopted Where was patient born? _____

VI. FINANCIAL ASSESSMENT

Do you currently use any of the following resources? ☐ Yes ☐ No
If yes, please indicate which ones.

☐ AFDC ☐ ECI/Child Team ☐ Food Stamps ☐ Home Nursing
☐ CIDC ☐ WIC ☐ SSI ☐ Other _____

Do you have any problems getting your child's medications? ☐ Yes ☐ No
Do you have any difficulties getting to your doctor's appointments: ☐ Yes ☐ No
Do you have a regular social worker or case manager? ☐ Yes ☐ No

VII. VALUES/BELIEFS ASSESSMENT

Religious preference: _____

Do you have any beliefs that might affect how we care for your child? (For example, some people refuse blood products or treatments, because it is against their religious/cultural beliefs). ☐ Yes ☐ No
Explain:

Date: _____ Parent/Guardian Signature: _____