North San Antonio Healthcare Associates

3338 Oakwell Court, Suite 107
San Antonio, Texas 78218-3087
(210) 822-3646

Confidential Self-Administered Child Health History **Date:** _____

Patient Name: _____ DOB: ____/____/_____ Age: _____
Address: _____ Emergency Contact: _____
City, State & Zip: _____ Phone #: _____
Phone: HM (____) _____ Allergies: _____
Parents: _____ Parents Work #: _____

Infant / Toddler (0 to 2 years)

Current Medications _____

_____

Birth and Development

Mothers Age at Birth _____ # of Times Pregnant Including Miscarriage _____
Prenatal Care Provider _____ Type of Delivery: ___ Vaginal ___ C-Section
Complications with Pregnancy _____
Place of Birth (Hospital, City, State) _____
Birth Weight _____ Birth Length _____ Blood Type _____
Complications During First few Days of Life _____
Feeding: Breast and/or Formula/Type_____ Current Diet _____

Childhood Health History (3-16 years)

Current Medications _____

_____

Social History

Have you ever used _____ Tobacco _____ Alcohol _____ Other Drugs _____ Weight Loss Medication
How often and How much _____
Do you have any questions about your body or sex? _____

Females Only

Age of start of periods _____ Are your periods regular? _____ Date of your last period _____
Do you have pain with your periods? _____ Any recent changes in your periods _____

Immunizations – Current _____ Yes _____ No

Medical History (Please include year and hospitalization (H) if required)

Vision Problems	Trauma/Injuries
Hearing Problems	Seizures
Ear Infections	ADD/ADHD
Strep Throat	Developmental Delay/Autism
Scarlet Fever	Chicken Pox
Allergies/Rhinitis	Anemia
Environmental Exposures (lead)	Surgeries
Asthma	Other
Pneumonia	Other
Constipation	Other
Bladder/Kidney Infections	Other
Eczema/Skin Conditions	Other
Bone / Joint Problems	Other

Family Medical History (Please include which relative)

Anemia/Blood Disorder _____
Heart Disease Before age 50 _____
Elevated Cholesterol _____
HTN/Stroke _____
Asthma/Allergy _____
Cancer _____
Diabetes _____
Epilepsy/Seizures _____
Kidney Problems _____
Muscle/Bone Disease _____
Genetic Disease or Major Birth Defects _____
Childhood Hearing Impairment _____
Tuberculosis _____
HIV Positive (who) _____
Dental Decay _____
Alcohol/Drug Abuse _____
Tobacco Abuse _____
Domestic Violence _____
Autism _____
ADD/ADHD _____
Learning Disorder _____
Mental Retardation _____
Psychiatric Disorder _____
Physical/Sexual/Emotional Abuse _____
Other _____
Other _____
Other _____

What are your current symptoms or reason for today's visit? _____
_____
_____
_____
_____

To the best of my ability, the answers I have given on this Health History are true.

Signature_____

Relationship to patient _____