Lincoln-Lancaster County Health Department

Child Health History

Child's Name:	Sex: ☐Male ☐Female	Birthdate:	Today's Date:

Child's Health History

Name of Doctor/Clinic:	City/State:	Phone number:

Were there any significant problems during pregnancy or birth? ☐No ☐Yes, Please explain:

Has your child had surgery or been hospitalized? ☐No ☐Yes, Please explain:

Date last seen by a healthcare provider(for reasons other than immunizations):

Medication

Does your child take medication on a regular basis? ☐No ☐Yes, Reason:

Name of medication(s), dosage and when taken:

Has your child had any of the following?

			Age of child or date of incident ▼
Asthma	☐No	☐Yes, describe:	
Other breathing problems	☐No	☐Yes, describe:	
Seizures or other neurological problems	☐No	☐Yes, describe:	
Heart or other cardiovascular problems	☐No	☐Yes, describe:	
Bladder or urinary tract problems	☐No	☐Yes, describe:	
Bowel or other GI problems	☐No	☐Yes, describe:	
Bone or joint problems	☐No	☐Yes, describe:	
Eczema or skin problems	☐No	☐Yes, describe:	
Frequent ear infections or tubes	☐No	☐Yes, describe:	
Other ear, nose or throat problems	☐No	☐Yes, describe:	
Chicken Pox or vaccination for such	☐No	☐Yes, describe:	
Diabetes or other endocrine problems	☐No	☐Yes, describe:	
Injury or abuse	☐No	☐Yes, describe:	
Car sickness	☐No	☐Yes, describe:	

Other describe:

Nutrition History

Is there any food or drink that your child should not eat for cultural, religious, personal reasons or medical reasons ***other than allergies***? (Note: use the allergy chart on the next page to list any allergies to food or drink)

☐ **Yes, list below** ☐ ***No, skip to next question***

Name or food/drink:	☐ Cultural	☐ Religious	☐ Personal	☐ Medical/describe:
	☐ Cultural	☐ Religious	☐ Personal	☐ Medical/describe:
	☐ Cultural	☐ Religious	☐ Personal	☐ Medical/describe:
	☐ Cultural	☐ Religious	☐ Personal	☐ Medical/describe:
Does your child have any problems with chewing or swallowing?	☐ No	☐ Yes, Please describe:		
Check the box if you have concerns about your child's:	☐ Eating habits	☐ Height	☐ Weight	
Please describe:				

Allergy History

Does your child have allergies or reactions (including intolerances) to food, medicine, insects, animals or other substances?

☐ ***Yes, please complete chart below*** ☐ ***No – Skip to Dental History***

Allergy Chart

Note: If your child has a food or milk allergy, we must have written documentation of the allergy from the doctor. For milk allergies, the doctor must also name a substitute for the milk.

Do you keep epinephrine (epi-pen) available at home for your child's allergy? ☐ Yes ☐ No

List each allergy or food separately	*Briefly describe child's reaction and/or check symptoms*	*Potential Severe Reaction**	*Doctor/Date of Diagnosis*
	☐ Hives ☐ Wheezing ☐ Runny nose ☐ Shortness of breath	☐ Yes ☐ No	
	☐ Hives ☐ Wheezing ☐ Runny nose ☐ Shortness of breath	☐ Yes ☐ No	
	☐ Hives ☐ Wheezing ☐ Runny nose ☐ Shortness of breath	☐ Yes ☐ No	
	☐ Hives ☐ Wheezing ☐ Runny nose ☐ Shortness of breath	☐ Yes ☐ No	
	☐ Hives ☐ Wheezing ☐ Runny nose ☐ Shortness of breath	☐ Yes ☐ No	
	☐ Hives ☐ Wheezing ☐ Runny nose ☐ Shortness of breath	☐ Yes ☐ No	

**** If the allergy has the potential to be severe, the child's health care provider should complete a medical statement and an allergy care plan should be completed.***

Additional information about allergy:

Dental History

Name of dentist:	Date last seen by dentist:	City/State:	Phone number:
How would you rate your child's dental health?	☐ Very good ☐ Somewhat good	☐ Fair ☐ Somewhat bad	☐ Very bad
Has your child ever had an injury to the teeth or gums?	☐ ☐ Yes, please explain:		
Has your child complained about pain in the teeth or gums?	☐ No ☐ Yes		
Is there fluoride in the water at your home, or is your child taking a prescribed fluoride supplement?	☐ No ☐ Yes		

Parental Concerns

Do you have any concerns about your child's vision?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's hearing?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's speech?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's behavior?	☐ No	☐ Yes, Please describe:
Do you have any concerns about your child's development?	☐ No	☐ Yes, Please describe:
Do you have any other concerns about your child?	☐ No	☐ Yes, Please describe:

Additional information regarding concerns: