alists

Patient name: ____________________________ DOB: _______________
Who completed form: _____________________ Date: _______________

Patient Health History – CST

Child Safety Team

1. **Allergic to medicine**: ____________________________________ Reaction: _________________________
2. Current Medications:

Name	Reason taken	How long taken
______________________________	_______________________	______________________
______________________________	_______________________	______________________
______________________________	_______________________	______________________
______________________________	_______________________	______________________
______________________________	_______________________	______________________

3. What doctor sees your child for routine health care? ____
4. Immunizations: ❑ Up to date ❑ Behind ❑ Unknown ❑ Doesn't get immunized

Past Medical History

4. Birth history (*circle*) Full term birth Premature _____ weeks Birth weight: ___________
   Complications with pregnancy: ____
   Complications with delivery: ____
   Complications after birth: ____

5. Hospitalizations / Surgeries / Injuries / Ingestions

Hospitalizations

Age	Hospitalized for:
____	________________________________
____	________________________________
____	________________________________

Surgeries

Age	Surgeries/procedures
____	________________________________
____	________________________________
____	________________________________

Injuries (*example: broken bones/stitches*):

Age	Injury
____	________________________________
____	________________________________
____	________________________________

Ingestions (*medication/other substances*):

Age	Substance ingested/inhaled
____	________________________________
____	________________________________
____	________________________________

4. Does your child have any chronic illnesses or see medical specialists?
   ____
   ____
   ____

5. Circle if your child has ever had any of the following developmental problems. List at what age it started:

	Age		Age		Age
ADHD	___	Delayed development	___	Autism	___
Learning disability	___	Speech problem	___	Other: _______________	___

Reviewed _______

Review of Systems

5. Does your child have any of the following symptoms or signs of illness? *(circle those that apply)*

- ❑ Fever
- ❑ Cold / earache / sore throat
- ❑ Swollen lymph nodes
- ❑ Vision or Hearing problems
- ❑ Dental problems
- ❑ Thyroid problems
- ❑ Heart problems / murmur
- ❑ Breathing problems /wheezing
- ❑ Nausea/vomiting /diarrhea
- ❑ Constipation / painful stools
- ❑ Bleeding problems / Anemia
- ❑ Genital rashes / sores / discharge
- ❑ Seizures/spells
- ❑ Headaches / vision changes
- ❑ Weight gain or loss
- ❑ Back/joint problems
- ❑ Skin rashes / infections
- ❑ Age started periods ______
- ❑ Last period ______________

Please Explain: ____

____

____

Behavioral History

6. Have you seen any behavioral changes that have concerned you? (*Check/circle all that apply and explain below.*)

- ❑ Nightmares / Night terrors
- ❑ Won't sleep alone
- ❑ Problems staying asleep
- ❑ Vague stomachaches
- ❑ Vague headaches
- ❑ Overeating
- ❑ Decreased appetite
- ❑ Frequent vomiting
- ❑ Enuresis/encopresis
- ❑ Acting out in school
- ❑ Skipping school
- ❑ In school suspension
- ❑ Out of school suspension
- ❑ Angry/Rebellious behaviors
- ❑ Aggressive behaviors/fights
- ❑ Lying/stealing
- ❑ Hurts themselves / cutting
- ❑ Hyperactive/impulsive
- ❑ Withdrawn/sad/depressed
- ❑ Emotional /cries easily
- ❑ Inappropriate sexual knowledge
- ❑ Inappropriate masturbation
- ❑ Sexual behaviors/acting out
- ❑ Foul language
- ❑ Runaway
- ❑ Fears
- ❑ Other ____

❑ Counseling *(who is child's counselor?)*: ____

Describe your concerns:

____

____

____

____

____

7. Do you have any other concerns about your child?

____

____

____

Education History

8. What school/daycare does your child attend? ____

   What grade is your child in? __________ Has he/she ever repeated a grade? *(Which?)* ___________

   Any learning problems? ____

   How is he/she doing in school this year? (grades, behavioral problems, suspensions, etc.,) ___________

   ____

   ____

   ____

Reviewed _______

Family Medical History

Health problems *(circle if present)*	**Mom** ✔	**or Mom's relatives** (list) *Describe*	**Dad** ✔	**or Dad's relatives** (list) *Describe*
Allergies/hayfever				
Asthma /emphysema				
Heart attacks/disease				
High blood pressure				
Strokes				
Overweight/Obesity				
Diabetes, adult -juvenile				
Cancer				
Infant heart defects				
Other birth defects				
Seizures/epilepsy				
Deafness in childhood				
Autism				
2 or more miscarriages				
Infant death (SIDS)				
Bleeding/excess bruising				
Blood clotting				
Liver problems				
Kidney problems				
Muscle problems				
Fragile bones/teeth				
Thyroid problems				
Skin conditions				
Mental retardation				
Bipolar disorder				
Anxiety/panic attacks				
Anger problems				
Depression				
Schizophrenia				
Smoking/Chewing tobacco				
Alcohol abuse				
Drug abuse/addiction				
Suicide				
Legal problems				
OTHER health problems				

Reviewed _______

Social History

9. **Mother**: ______________________________ Age: _______ Education: _________________________

❑ Biological ❑Step ❑ Adoptive Where employed: _________________________

❑ Other ______________________________

List who lives in mother's home:

Name	Age	How related to patient
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________

10. **Father**: ______________________________ Age: ______ Education: _________________________

❑ Biological ❑Step ❑ Adoptive Where employed: _________________________

❑ Other ______________________________

List who lives in father's home*: (if parents live in different homes)*

Name	Age	How related to patient
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________

11. Who else helps take care of your child? ____

____

____

12. Other brothers or sisters not listed above (*such as -half or -step siblings*):

Name	Age	How related to patient and where they live
______________________	_____	______________________
______________________	_____	______________________
______________________	_____	______________________

13. Stresses/changes that have affected your child during the past year (*Check/circle all that apply.*)

❑ Marriage ❑ Separation/Divorce ❑ Job loss ❑ Moves ❑ Legal problems ❑ Serious illness

❑ Deaths ❑ Change schools ❑ Births ❑ Financial ❑ Other ________________________

Please Explain: ____

____

14. What seems to be the greatest challenge for your child? ______________________________________

____

15. What is it that makes you proud of your child? ____

____

____

Reviewed _______