

Chiricahua Community Health Centers, Inc.
Child Health Record

Name _____ Date of Birth _____
Age _____ Todays Date _____

Names	Occupations	
Father:		Child Lives with:
Mother:		
Sisters:	Who gives most of the child care?	
Brothers:	Living quarters type:	

On a regular basis, does the child go to: (Check any that apply) Day care baby sitter preschool school

At what age did the child: **Sit up** _____ **Crawl** _____ **Walk** _____

During baby's first year was he/she: Breast Fed? Y/N Formula? Y/N How long?

Weaned from Breast milk or formula at age: _____

Whole milk started at age? _____ Problems? _____

Solid foods started at age? _____ Problems? _____

Age child was daytime potty trained? _____ Nighttime potty trained _____

Mother's history during pregnancy	Yes	No	Mother's history during pregnancy	Yes	No
High blood pressure?			Diabetes or Sugar in your urine?		
Take any medications?			Smoke Cigarettes?		
Drink alcohol?			When did prenatal care begin?		
Did you have a difficult labor			Was the child delivered prematurely?		
Did your baby cry/breathe immediately at birth?			Did the baby have jaundice at birth?		
Did the baby stay in the hospital after your discharge?			Did the baby have an RH problem/receive blood?		

Has this child ever had any of the following? (check all that apply)

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Head lice | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Parasites | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Hodgkin's Disease |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Fever convulsions | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> ADD |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Accidents |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Medicine Allergies | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Environmental Allergies | |

Please explain any of the above as necessary:

Has any blood relative of this child ever had any of the following? (check all that apply)

- | | | | | |
|-------------------------------------|--|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mental Illness |

Does your child have any on-going problem that concerns you? (check all that apply)

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Eats too little | <input type="checkbox"/> Eats too much | <input type="checkbox"/> Cries a lot | <input type="checkbox"/> Won't sleep | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Constipated | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Speaks unclearly | <input type="checkbox"/> Sees poorly |
| <input type="checkbox"/> Wets bed | <input type="checkbox"/> Frequently has a cough or runny nose | | <input type="checkbox"/> Doesn't respond to noise or spoken word | <input type="checkbox"/> Seems small for age |

Any other problem that you'd like to like to discuss: