Cogdell
Family Clinic

Child Health History

Today's Date:

Patient's Full Name _____

Date of Birth: _____

Mother's Name: _____ Lives with Child: Y N

Father's Name: _____ Lives with Child: Y N

Guardian Name: _____ Lives with Child: Y N

Allergies:

Current Medications:

Medication / Supplement	Date Started	Dose	Frequency

Current or Past Medical Problems: please circle all that apply

Heart Problems Heart Murmur Asthma Obesity Head Injury

Diabetes Developmental Delay Cancer What type: _____

Broken Bones Other: _____

Surgeries: please circle all that apply:

Tonsillectomy/Adenoidectomy Gallbladder Appendectomy

Other: _____

Does the child drink soft drinks? No Yes how many? _____ How Often? _____

Does the Child Smoke: No Yes how many? _____ How Often? _____

Does the Child Drink alcohol? No Yes How much? _____ How Often? _____

Does the child use recreational Drugs? No Yes What? _____ How Much/Often?_____

Does the Child's Parents, Grandparents or siblings have: please check all that apply

	Mother	Father	Siblings B-Brother S-Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer							
High Blood Pressure							
Heart Disease							
Leukemia							
Diabetes							

How much water does the child drink a day? _____

How much time does the child spend playing video games each day?_____

How much time does the child spend watching television each day? _____

How much physical activity does the child get a day? 0-30 minutes 30-60 minutes > 60 minutes

When was the child's vision last checked? _____

When was the child's last dental visit? _____

Dentist's name: _____ City: _____

What is the reason for your visit today? _____

_____

Other concerns you have regarding your child you would like to discuss: