PONCA TRIBE OF NEBRASKA

HEALTH HISTORY FORM - CHILD

(Please Print)

Patient's Last name: First: Middle:	Today's date: / /	Birth date: / /	HRN#

ALLERGIES AND ANY DRUG ALLERGIES:

_____
_____
_____
_____
_____

LIST ANY PRESCRIPTION DRUGS YOU TAKE:

_____
_____

LIST ANY NON-PRESCRIPTION DRUGS YOU TAKE:

_____
_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILDS HISTORY:

YES NO

___ ____ Were there any complications during pregnancy?
___ ____ Were there any complications during the birth and delivery?
___ ____ Was the pregnancy full-term (9 months or 40 weeks)?
___ ____ Were there any problems with the child immediately after birth?
___ ____ Did the child go home with mother?
___ ____ Did the child have any problems with jaundice?
___ ____ Does the child have any birth defects?
___ ____ Does the child have any problems with feeding or nutrition?
___ ____ Has the child's growth and development been normal?
___ ____ Are the child's immunizations up-to-date?
(Please have the child's immunization records available)
___ ____ Does anyone in the child's home smoke?
___ ____ Is your child exposed to sources of lead that you know about?

LIST ANY INJURIES OR FRACTURES (ALSO LIST AGE):

_____
_____
_____
_____

LIST ANY OPERATIONS (ALSO LIST AGE):

_____
_____
_____
_____

LIST ANY HOSPITALIZATIONS (ALSO LIST AGE):

_____
_____
_____
_____

HEALTH HISTORY OF PATIENT

Have you ever had or are currently having?

YES NO

___ ____ ANEMIA (low blood count)
___ ____ ARTHRITIS
___ ____ ASTHMA
___ ____ BRONCHITIS OR PNEUMONIA
___ ____ CANCER
___ ____ CHICKEN POX
___ ____ DENTAL PROBLEMS
___ ____ DIABETES MELLITUS
___ ____ EAR INFECTIONS
___ ____ EPILEPSY/SEIZURE DISORDERS
___ ____ GERMAN MEASLES
___ ____ HAYFEVER/SEASONAL ALLERGIES
___ ____ HEARING PROBLEMS
___ ____ HEART DISEASE
___ ____ LEARNING/ATTENTION DIFFICULTIES
___ ____ MEASELS
___ ____ MENTAL OR EMOTIONAL PROBLEMS
___ ____ MONONUCLEOSIS
___ ____ MUMPS
___ ____ RHEUMATIC FEVER
___ ____ TONSILLITIS OR STREP THROAT
___ ____ VISION PROBLEMS (NOT glasses)
___ ____ WEIGHT PROBLEMS
___ ____ OTHER (please list):

_____
_____
_____

PLEASE LIST ANY ADDITIONAL PROBLEMS, CONCERNS, OR INFORMATION ABOUT YOU OR YOUR FAMILY THAT YOU WOULD LIKE THE HEALTH CARE PROVIDER TO KNOW ABOUT:

_____
_____

FAMILY HISTORY OF PATIENT

YES NO

___ ____ ANEMIA
___ ____ ARTHRITIS
___ ____ BIRTH DEFECT
___ ____ BLEEDING TENDENCY
___ ____ CANCER
___ ____ DEAFNESS
___ ____ DIABETES MELLITUS
___ ____ DRINKING OR DRUG PROBLEMS
___ ____ EPLIEPSY/SEIZURES
___ ____ GLAUCOMA
___ ____ HEART ATTACK OR HEART DISEASE
___ ____ HIGH BLOOD PRESSURE
___ ____ MENTAL/EMOTIONAL PROBLEMS
___ ____ NERVE OR MUSCLE DISEASE
___ ____ OBESITY
___ ____ STROKE
___ ____ SUICIDE/ATTEMPTED SUICIDE
___ ____ TUBERCULOSIS
___ ____ OTHER (please list):

_____
_____
_____

PATIENT SIGNAURE: _____

DATE: _____