

EPSDT/HealthCheck Health History Form

7-20 Years

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Your Name: _____ **Relationship to child:** _____

Childhood

Has your child ever been treated for or diagnosed with:

- Asthma or wheezing _____
- Pneumonia _____
- Lung problems _____
- Heart murmur _____
- Anemia _____
- Recurrent ear infections _____
- Hearing problems _____
- Vision or eye problems _____
- Urinary tract infections _____
- Stomach or digestive problems _____
- Seasonal allergies or eczema _____
- Seizures _____
- Broken bone(s) _____
- Learning disability _____
- Other chronic medical problems _____

Has your child ever been hospitalized?

- No Yes Why? _____

Previous surgeries: _____

Please list any specialists, including counselors, your child is currently seeing and reason: _____

Developmental

Do you have concerns about any of the following:

- The way your child uses his/her arms, fingers or legs
- Speech problems
- Vision (Are you concerned about your child's vision?)
- Hearing (Are you concerned about your child's hearing?)

Puberty

Concerns about:

- Body changes
- Sexual activity
- Sexually transmitted infection
- Discharge: vaginal or penis
- Contraception

For Girls:

Age of first menstrual period? _____

Social Emotional/Stress Indicators

Does your child have problems with:

- Depression/ anxiety _____
- ADD/ADHD _____
- School attendance
- Getting along with other children including siblings
- Getting along with parents or other adults
- Problems with sleeping or nightmares
- Bad temper/breath holding/jealousy
- Nail biting/thumb sucking
- Bedwetting (after 6 years)
- Threaten to harm self, others or animals
- Sexual acting out
- Destroying property
- Drug use, alcohol use or smoking

Exposure Risks

- Passive smoke Cigarettes E-Cigs Chew
- Alcohol Other drugs _____
- Access to weapons Has a weapon(s)
- Excessive television/video game/internet/cell phone use
- Hours per day: _____ Who supervises usage? _____
- Wears protective gear, including seat belts? Yes No
- Any concerns about lead exposure (old home, plumbing, peeling paint)? Yes No

Medications

Current medications and dose: _____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

Nutrition

- Has your child had any dietary problems? _____
- Unexplained weight gain
- Unexplained weight loss
- Food allergies: _____

Dental

- Problems with teeth or gums
- Bad breath
- Has your child been seen by a dentist? Yes No
- If so, date of last exam: _____
- Why did he/she see the dentist? _____

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed Mental Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____				

Other Concerns/Issues:

Reviewed by: _____

Date: _____

Some responses may indicate adverse childhood experiences and may require further evaluation. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. For assistance phone 844-HELP4WV (844-435-7498).