

**CHILD HEALTH STATUS COMPONENT**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_ Race/Eth. \_\_\_  
Completed by \_\_\_\_\_ Assessment date \_\_\_/\_\_\_/\_\_\_ Update \_\_\_/\_\_\_/\_\_\_

<b>Primary Physician</b>	<b>Dentist</b>
Name _____	Name _____
Address _____	Address _____
_____	_____
Telephone ( ) _____	( ) _____
Date of last physical exam _____	Date of last physical exam _____

Past medical/dental provider  
Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

<b>BIRTH FAMILY HISTORY</b>	
<u>Biological mother</u>	<u>Biological father</u>
Current health status _____	Current health status _____
Emotional disorders _____	Emotional disorders _____
History of family violence? Yes ___ No ___	
Family history of alcohol or drug abuse? Yes ___ No ___	
Genetic Disorders? Yes ___ No ___ List _____	
Other relevant information _____	
_____	

**CHILD'S MEDICAL HISTORY**

Allergies/Drug Sensitivities \_\_\_\_\_

Surgery/hospitalizations \_\_\_\_\_

Injuries \_\_\_\_\_

Communicable Diseases \_\_\_\_\_

Present medical problems \_\_\_\_\_

Developmental/learning problems \_\_\_\_\_

Significant behavioral problems \_\_\_\_\_

Has DEC evaluation been done? Yes \_\_\_ No \_\_\_ Date of Evaluation \_\_\_\_\_

Diagnosed mental disorder/emotional illness \_\_\_\_\_

Glasses/contacts required? Yes \_\_\_ No \_\_\_ Hearing aid required? Yes \_\_\_ No \_\_\_

Current dental problems \_\_\_\_\_

Special dietary needs \_\_\_\_\_

Additional health information \_\_\_\_\_

(Attach brief summary of relevant health/social history that may impact health care delivery)

**Current medications**                      **dosage**                      **why prescribed**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**Immunization status**

Current \_\_\_ 1-2 immunizations behind \_\_\_ More than 2 immunizations behind \_\_\_ Unknown \_\_\_

(Attach copy of immunization record)