FAMILY MEDICAL CENTER

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Health Plan

EPDST HEALTH HISTORY

Child's Name			
Gender ☐ Male ☐ Female	Race	Social Security Number	Date of Birth

Please list all people in household:

Name	Date of Birth	Occupation	Education
Father			
Mother			
Other			
Other			
Other			
Other			
Other			

Have there been any recent major changes or stresses in the child's life? ☐ Yes ☐ No
If Yes, explain:

Does the child go to a babysitter, preschool, or day care regularly? ☐ Yes ☐ No

BIRTH HISTORY

Birth Weight	Length	Place

During the pregnancy did the mother see a doctor regularly? ☐ Yes ☐ No

During the pregnancy did the mother: (If YES, explain)

- Have any medical problems? ☐ Yes ☐ No Explanation:
- Smoke? ☐ Yes ☐ No Explanation:
- Use any medications? ☐ Yes ☐ No Explanation:
- Use alcohol or drugs? ☐ Yes ☐ No Explanation:
- Have problems with labor? ☐ Yes ☐ No Explanation:

How long did the baby stay in the hospital after birth?

PAST MEDICAL HISTORY

Is the child's general health: ☐ GOOD ☐ FAIR ☐ POOR (Check one)

Does the child have allergies? ☐ YES ☐ NO If yes, explain:

Is the child taking any medications? ☐ YES ☐ NO If yes, explain:

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

	Date:
	Date:
	Date: