Nez Perce Tribe Mamáy'asnim Hitéemenwees

Child Health History Form

Child's Name: _____ **DOB:** _____ Male☐ Female☐

Child's Primary Care Information

Child's Primary Care Provider: _____

Primary Care Provider Phone Number: _____

Does the Child receive W.I.C.? Yes ☐ No ☐

Does the child have access to regular medical care: Yes ☐ No ☐

If "Yes, where _____

Does the child have access to regular dental care: Yes ☐ No ☐

If "Yes," where _____

Child's Past Medical History

Check mark appropriate column and provide additional information in comment section below.

Illness/Condition	Yes	No	Illness/Condition	Yes	No
Allergies			Lead Poisoning		
Anemia			Measles		
Asthma			Meningitis		
Cancer/Leukemia			Mumps		
Chicken Pox			Orthopedic Problems		
Diabetes			Pneumonia		
Frequent Colds			Rheumatic Fever		
Frequent Ear Infections			Rubella		
Frequent Sore Throats			Seizures/Convulsions		
Gastroesophageal Reflux			Sickle Cell		
Hearing Problems			Speech Problems		
Heart Disease			Surgeries		
Hepatitis			Tuberculosis		
Hospitalizations			Visual Problems		
Kidney Disease			Whooping Cough		

COMMENTS for each "YES" answer. *(If your child needs accommodation for any illness/condition, additional forms may be needed)*

Complete other side

Date of Last Physical Exam	Date of Last Dental Exam
Name of Health Care Provider who completed exam	Name of Dental Provider who completed the exam

Birth History

Did mother experience any difficulties during pregnancy or delivery: Yes ☐ No ☐

Please Explain if "Yes"

Current Medical History

	Yes	No	Comments/Additional Information
Is the child presently being treated for any medical, mental, or disabling condition?			
Does the child currently require any medications and/or medical procedures?			

Developmental / Mental Health Information

Is your child potty-trained: Yes ☐ No ☐

Have there been any significant changes (positive or negative) in your child's life within the past 12 months that may affect your child's emotional well-being? Yes ☐ No ☐

If "Yes," please explain

Infants Only

Name of child's infant formula

How Much How Often

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Parent/Guardian Signature: **Date:**