Riverside University Health System - Behavioral Health
CHILD'S MEDICAL, MEDICATION, AND PRENATAL HISTORY

CHILD'S NAME: _____ SS#: _____

AGE: _____ DATE OF BIRTH: _____ DATE: _____

In order to provide the best mental health care, it is necessary to know some things about your child's physical condition. Please answer the following questions as best you can. Someone will assist you if necessary.

MEDICAL:

HAS YOUR CHILD EVER HAD: (Please write in "yes" or "no" next to each question)

Ear, nose, and throat problems? _____ Frequent colds? _____ Frequent earaches? _____

Other? _____

Eye problems? Infections? _____ Wears glasses? _____ Other? _____

Stomach or intestinal problems? _____ Frequent stomachaches? _____ Vomiting? _____ Diarrhea? _____

Soiling? _____

Lung problems? Cough? _____ Asthma? _____ Pneumonia? _____

High fevers?_____ Convulsions? _____

Heart problems? "Blue Baby"? _____ Other? _____

Urinary problems? Bladder infection? _____ Persistent wetting? _____

Other? _____

Allergies? _____ Sneezing, always runny nose? _____ Itching? _____ Food or medication sensitivity? _____

Other? _____

Surgery? _____

Injury? (Including head injury) _____ Near drowning? _____ Poisoning? _____

Other? _____

Is child under a doctor's care regularly (except for routine physical, immunization, occasional illness)? _____

Does your child need to see a doctor for physical problems? _____

Please give a short explanation of questions answered "yes."

_____

_____

_____

_____

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MEDICATION Please write answers to each of the following questions:

What prescription medication is child currently taking? (Include dose and frequency) _____

_____

_____

_____

_____

What non-prescription medication is child currently taking? _____

_____

_____

What medications has the child taken in the past six months? _____

_____

_____

Has any medication produced allergic or other adverse symptoms? If so, name medication and describe symptoms.

_____

_____

_____

Give brief child and family history of drug and/or alcohol use. _____

_____

_____

_____

PRENATAL

DURING PREGNANCY WITH THIS CHILD:

Prenatal care starting at what month? ___ Any bleeding? ___ High blood pressure? ___ Anemia? ___

Nutrition? Adequate? _____ Inadequate? _____

Smoking? _____ If yes, how much? _____

Drinking? _____ If yes, how much? _____

Drugs - Prescribed? ___ Name? _____

Non-Prescribed? ___ Name? _____

Delivery: At what month of pregnancy? _____ Was labor induced? _____ Duration in hours? _____

Condition of infant immediately after birth, and during first month. _____

_____

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_____

_____

Parent/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Printed Name/Discipline: _____