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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Child's Name: _____ **SSN:** _____

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. _____

Parent/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____

Printed Name/Discipline: _____

