Advocate Children's Hospital

CHICAGOLAND & NORTHWEST INDIANA
Ronald McDonald House Charities

Ronald McDonald Care Mobile

1675 W. Dempster ~ Park Ridge, IL 60068
Phone 847-723-7358 ~ Fax 847-723-9459

4440 W. 95th Street ~ Oak Lawn, IL 60453
Phone 847-723-7358 ~ Fax 708-684-4716

Child History Form

*****All information must be completed in order for you child to be seen*****

Child's Name_____ Date of Birth_____ Male__ Female__
Address_____ City_____ Zip Code_____

Last visit to regular doctor_____ Reason_____
Last visit to dentist _____ Last vision test_____
How many days has child missed from school in the past year? _____ Reason(s)_____
How many times has child been in the emergency room in the past year? ___ List reasons _____
_____

Has your child had any health problems or major illnesses?

Asthma	Yes	No	Diabetes	Yes	No
Birth defects	Yes	No	Heart problem/shortness of breath	Yes	No
Loss of function of body part	Yes	No	Heart murmur, high blood pressure	Yes	No
Sickle cell/hemophilia	Yes	No	Dizziness or chest pain with exercise	Yes	No
Bone/joint problems	Yes	No	Ear/hearing problems	Yes	No
Developmental delay	Yes	No	Eye or vision problems	Yes	No

Has your child had any overnight hospitalizations or any surgeries? _____
Taking any medication (list) _____
Allergic to any medication/foods/other (list) _____
Any reaction to previous immunizations: (circle) fever 104 or more, seizure, severe allergic reaction, rash, or change in mental state. Other_____ None____

Family history of child being seen: Place the letter of family member who has each problem on chart below—**M**other, **F**ather, **S**ister, **B**rother, **G**randparent, **A**unt, **U**ncle.

Heart disease	Asthma
Stroke	Seizures
High blood pressure	Cancer
Diabetes	Other

Has anyone in family had sudden death before age 50? Yes____ No____ If so, reason_____
_____
Anything else you would like us to know about your child or any special concerns?
_____

Parent/legal guardian signature_____
Printed name_____ Date_____

FOR OFFICE USE ONLY:
Above patient history reviewed ( )
Current Complaints:_____
( )School performance assessed ( )Nutrition/activity assessed ( )Development for age assessed ( ) Behavioral concerns
Adolescents: HEADSS assessment: _____ ( ) no concerns
Physical Exam positive findings (see school form for vitals): _____
Assessment: ( ) Well Child/Adolescent ( ) Overweight ( ) Nutritional Risk ( ) Other _____
Plan: Immunizations: _____ Screenings: ( ) Hgb ( ) Lead ( ) Glucose ( ) STI
Health Education: ( ) Nutrition ( ) Activity ( ) Safety ( ) Safe Sex ( ) _____
Follow-up (also see referral/parent notification form): _____
Provider _____ Printed Name _____ Date _____