1300 Woodland Avenue
West Des Moines, IA 50265,
Phone: 515-280-3860
Fax: 515-309-0686

UCS Healthcare Children's Medical History

Child's name:	
Date of birth:	
Name of parent/caregiver completing form:	

Why are you here today? Any Specific Concerns?

Please list the child's daily medications, vitamins, supplements.

Medication Allergies, including type of reaction

Medication	Reaction	Date of onset (if known)

Other Allergies (Foods, Environmental) Including reaction

Allergy to:	Reaction	Date of onset (if known)

Past Medical History

Any Pregnancy complications? Y N

Comments:

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Labor and Delivery (please circle your response)

Born on Due Date Y N	Uncomplicated Labor Y N
Born Early Y N	Child did well after delivery and went home on time Y N
Born Late Y N	C-Section Y N
# of days Early or Late	Vaginal Delivery Y N

Comments on labor / Delivery

Ongoing medical problems:

Medical problems child has had in the past and has recovered from:

Surgeries, including dates:

Surgery	Any issues?	Date of surgery

Hospitalizations and other serious injuries:

Immunization History

Is child in the IRIS Iowa vaccine registry? Y N	Last Tetanus shot?	Last flu vaccine?	Ever had chicken pox? If yes, include date.	Last TB test? If yes, was it negative or positive?

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Are the child's immunizations up to date? Y N

Immunization Comments:

Family History- Please check all that apply

Diagnosis	Mother	Father	Sibling	Child	Grandparent	Other
Diabetes						
Glaucoma						
Cancer						
Type of Cancer:						
Heart Attack						
Chest pain						
Stroke						
High blood pressure						
High Cholesterol						
Alcoholism						
Drug Addiction						
Depression						
Suicide						
Other (fill in)						

Family Information:

Parent #1

Name:
Occupation:

Parent #2

Name:
Occupation:

Stepparents, other guardians/caregivers:

Current living situation:

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Siblings (names and ages)

Name	Age

Anyone else in the household?

Daycare / Babysitter Information (Who and how many hours a day?)

Is the child in school? Where at, what grade are they in?

Recent significant changes in the child's life:

Lifestyle

Please list activities they enjoy:

How healthy is the child's diet?

- ❑ Not healthy
- ❑ Fairly healthy – could be better
- ❑ Healthy – I try my best
- ❑ Excellent

How often do the child at least 30 minutes of mild to moderate exercise?

- ❑ Never
- ❑ 1-3 times per month
- ❑ 1-3 times per week
- ❑ 4-6 times per week
- ❑ Daily
- ❑ Other:_____

On average, how many hours of sleep does the child daily?

- ❑ Less than 6 hours
- ❑ 6-8hours
- ❑ 9-12 hours
- ❑ More than 13 hours

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ucs healthcare
your partner in total health

On average, how much caffeine does the child drink/eat daily? (this includes coffee, tea, soda, energy drinks, caffeine supplements) Please describe the number and type of caffeine they use: _____

On average, how many servings of dairy does the child have daily?_____

On average, how many hours of screen time does the child have daily?_____

Is the child exposed to smoking or tobacco use? If yes, who and how many hours daily?
_____

Dentist:	How many times do they brush daily?
Last visit:	Other:

Safety (please circle or fill-in the information)

Type of car restraint used?	Helmet use for biking, skating etc: Always Sometimes Never	Exposure to: Lead Asbestos Radiation Other Chemical	Does the home have smoke detector? Y N	Last time battery was changed?
Restraint used: Always Sometimes Never	Other Safety concerns:			

Any other information you would like us to know about you or your child (other providers they see, special concerns:

In order to keep our records current and provide optimal care, please let us know if there are any changes to this information at each appointment. Thank you for allowing us to serve your healthcare needs.

TJ Guthrie, ARNP

David Huante, MD

LeeAnn Albright, ARNP

Mollie O'Brien, ARNP

Joshua Tessier, MD

Frank Filippelli, DO