MCH/HEALTH TRACKS HEALTH HISTORY

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 1818 (Rev. 08-2008)

Clear Fields

Program:			
Name:	Date of Birth:	Race:	Sex: ☐ M ☐ F
Address:	City:	State:	Zip Code:
Medicaid Number:	Social Security Number:	Telephone Number 1	Telephone Number 2
Information Provided By:	Other Agencies Involved:		Child Lives at Home: ☐ Yes ☐ No

FAMILY/HOUSEHOLD

NAME LAST FIRST (MAIDEN)	SEX	MARITAL STATUS	RELATIONSHIP TO CHILD	DATE OF BIRTH	RACE

FAMILY HISTORY

	No	Maternal Side	Paternal Side	Siblings		No	Maternal Side	Paternal Side	Siblings
Cancer	☐	☐	☐	☐	Mental Health (Depression, Suicide, Bipolar, ADHD, etc.)	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Communicable Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Alcohol Use	☐	☐	☐	☐
Allergies/Asthma	☐	☐	☐	☐	Drug Use	☐	☐	☐	☐
Birth Defects/Congenital Abnormalities	☐	☐	☐	☐	Tobacco Use	☐	☐	☐	☐
Convulsions/Seizures	☐	☐	☐	☐	Other	☐	☐	☐	☐

PAST HEALTH HISTORY

Prenatal History:			Number of Alcoholic Drinks Consumed During Pregnancy:
Condition of Infant at Birth:			Mother's Age When Infant Was Born:
Premature ☐ No ☐ Yes-Number of weeks: _____	Birth Weight:	Length at Birth:	Birth Order in Family:

HAS CHILD EVER HAD:	NO	YES	COMMENTS	HAS CHILD EVER HAD:	NO	YES	COMMENTS
Communicable Diseases (Chicken Pox, Measles, RSV, etc.)	☐	☐		Skin Disorders (Dermatitis, Eczema, Rashes)	☐	☐	
Convulsions/Seizures	☐	☐		Vision Disorders (Surgery, Glasses, Eye Patch, etc.)	☐	☐	
Breathing Disorders/Asthma	☐	☐		Surgery/Accidents/Serious Injuries/Fractures	☐	☐	
Allergies	☐	☐		Learning Disabilities/ADHD	☐	☐	
Ear Infections	☐	☐		Other	☐	☐	

CURRENT MEDICATIONS

Is child currently taking all medications as prescribed? ☐ Yes ☐ No, why not? See Summary.

Date Immunization Record Obtained ☐ Check box if attached to chart

DEVELOPMENTAL REVIEW

Does the Child Have Trouble In Any Of The Following Areas **Now**:

Sleeping	☐ Yes ☐ No	Bedwetting	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No
Speech Problems	☐ Yes ☐ No	Frequently Ill	☐ Yes ☐ No	Gaining Weight	☐ Yes ☐ No
Temper Tantrums	☐ Yes ☐ No	Appetite	☐ Yes ☐ No	Excessive Fears	☐ Yes ☐ No
				Nightmares	☐ Yes ☐ No

Is the child difficult to parent? ☐ Yes ☐ No

Are There Any Other Problems Not Mentioned Above?

SCHOOL INFORMATION		HEALTH-CARE PROVIDERS	DATE LAST SEEN
What Grade Is The Child Presently In?	Name of School:	Doctor:	
Is The Child In Any Special Classes (Speech, Reading)? ☐ Yes ☐ No		Eye Doctor:	
Does The Child Take Part In Other Activities (Sports, Music)? ☐ Yes ☐ No		Dentist:	
Have There Been Any Changes In School Performance? ☐ Yes ☐ No		Specialist:	
Comments:		Counselor:	
		Other:	

Have Parents Talked To Child About: (Check All That Apply)
☐ Physical Changes ☐ Sex ☐ Menstruation ☐ Birth Control ☐ Wet Dreams ☐ Sexually Transmitted Disease (AIDS, HPV, etc.)

Do Parents Have Any Concerns About: (Check All That Apply)
☐ Drinking Alcohol ☐ School Performance ☐ Drugs ☐ Changing Attitude ☐ Choice of Friends ☐ Peer Pressure ☐ Eating Patterns

Is The Child: (Check All That Apply)
☐ Working ☐ Dating ☐ Sexually Active ☐ Using Birth Control ☐ Self-Mutilation

Referred To Family Planning ☐ Yes ☐ No

Any Changes in the Family:
☐ Separation of Parent or Family Member/Divorce ☐ Recent Move, date: _____ ☐ Loss of Job
☐ Death of a Close Friend or Relative ☐ Gain of a New Family Member

Does the Family Have Someone to Call for Help in Case of Family Problems?

SUMMARY:

Signature of Intake Worker:	Date:

CONSENT

As parent/legal guardian/self. I hereby give my consent to release screening assessment information and to have him/her/myself undergo laboratory tests, examinations, and immunizations under the MCH/Health Tracks program for completion of the screening, diagnosis, and treatment and waive any legal action against any/all persons conducting the program. Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect participation in this program.

Signature:	Date:	Witness Signature:	Date: