



Ronald McDonald Care Mobile



Child History Form

*****Please complete as much information as possible for us to best care for your child*****

Child's Name	Date of Birth
Last visit to regular doctor	Reason
Last visit to dentist	Last vision test

How many days has the child missed from school in the past year? _____ Reason(s) _____
Were any because the required physical or immunizations were not complete? Yes No

Has the child been in the Emergency Room in the past year? Yes No
If yes, please list reasons: _____

Has the child had any overnight hospitalizations or any surgeries? Yes No If yes, please list: _____

Please list the child's medications: _____

Please list allergies to any medication/foods/other: _____

Has the child had any reaction to previous immunizations: (please circle)
NONE fever (104 or more) seizure severe allergic reaction rash change in mental status

Does the child have any health problems or major illnesses below?

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problem (heart murmur, high blood pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle cell/hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness or chest pain with exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone/joint problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear/hearing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental delay	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye or vision problems, wears glasses or contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioral concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (please list):	

Child's Family History: Place the letter of family member who has each problem on chart below—**M**other, **F**ather, **S**ister, **B**rother, **G**randparent

Heart disease	Asthma	High blood pressure	Cancer
Stroke	Seizures	Diabetes	Sudden death before age 50

Please mark yes or no for the following statements:

- Yes No In the past 12 months, our family has run out of food before we had money to buy more
- Yes No In the past 12 months, our family has worried we would not have enough food before we had money to buy more
- Yes No The child is exposed to cigarette smoke in the home
- Yes No There is a gun in the home where the child lives or spends a lot of time
- Yes No The child wears a seat belt in the car
- Yes No The child owns a bike helmet
- Yes No The child is in need of mental health/behavioral health resources

Please list anything else you would like us to know about the child or any special concerns?

Printed name	Date:
Parent/legal guardian signature	