MCH/HEALTH TRACKS HEALTH HISTORY FORM (SFN 1818) GUIDELINES

Statement of Intent: This form is to be used for each infant/child/young adult (ages 0 - 21) admitted for child health services, (i.e., Child Health Nursing Conference, ND Health Tracks (EPSDT), High Priority Infant, Well Child Clinic, Head Start, etc.).

Program: Program for which infant/child/adolescent is being admitted.

Demographic Data:
Name: First and last name plus middle initial.
Date of Birth: Birth date.
Race: Document race(s).
Sex: Gender.
Address: Family address.
Medicaid Number: Medicaid number when applicable.
Social Security Number: Social Security Number
Telephone: Family telephone number(s)
Information Provided By: The person history information is obtained from and relationship to infant/child/young adult, (i.e., parent, grandparent, childcare provider, legal guardian, etc.).
Other Agencies Involved: Agencies involved in care, (i.e., WIC, MCH, Head Start, ND Health Tracks (EPSDT), Foster Care, Human Service Centers etc.).
Child Lives at Home: Does the child live at home with a parent?

Family/Household Members:
Information on all persons living in home with infant/child/young adult, (i.e., parents, siblings, grandparents, non-relatives, etc.):

Last Name
First Name
Maiden name
Sex
Marital Status
Relationship to Child
Date of Birth
Race

If more space is needed to record family or other members living in household use summary section or progress notes.

Family History:
Place X under "no" for a negative answer. For any of the diseases experienced by family members including mother, father, mother's parents and grandparents, father's parents and grandparents, or sibling indicate the number of family members who have experienced this disease under maternal or paternal side.

Cancer: Self-explanatory.
Heart Disease: Hypertension, heart attack, stroke, etc.
Diabetes: Diabetes (Type I or Type II).
Allergies/Asthma: Drug reactions, "hay fever," etc.
Birth Defects/Congenital Abnormalities: Self-explanatory

Convulsions/Seizures: Self-explanatory.
Mental Health: Depression, suicide, bipolar, ADHD, etc.
Communicable Disease: Tuberculosis, HIV, AIDS, hepatitis, STD's, etc.
Alcohol use: Self-explanatory.
Drug use: Self-explanatory.
Tobacco use: Self-explanatory.
Other: Other diseases or conditions not listed above occurring in family, (i.e., arthritis, cystic fibrosis, etc.).

Past Health History:
Prenatal History: Mother's physical/emotional condition during pregnancy, (i.e., healthy, gestational diabetes, toxemia, premature labor, use of alcohol, tobacco, or other drug use, etc.).
Approximately How Many Alcoholic Drinks Were Consumed During Pregnancy: Self-explanatory.
Condition of Infant at Birth: Infant's physical condition at time of birth. Conditions may include, healthy, low Apgar scores, meconium stained fluid, low birth weight, prematurity, breathing problems, birth defects, etc.).
Premature: "No" or "yes." If yes, number of weeks gestation.
Birth Weight: Self-explanatory.
Length at Birth: Self-explanatory.
Birth Order in Family: Placement of infant in family, (i.e., first child, second child, etc.). If applicable list if child is second of four children, first of two children, etc.
Communicable Diseases: Chickenpox, measles, RSV, etc.
Skin Disorder: Dermatitis, eczema, rashes, etc.
Convulsions/Seizures: Were they fever induced? Is child on medication for seizure?
Vision Disorders: Surgery, glasses, eye patch, etc.
Breathing Disorders/Asthma: Self-explanatory.
Surgery/Accidents/Serious Injuries/Fractures: Give explanation if yes.
Allergies: Self-explanatory.
Learning Disabilities/ADHD: Self-explanatory (ADD, dyslexia, etc.)
Ear Infections: Frequency if answered yes.
Other: Other health-related problems (i.e., head lice, etc.).

Current Medications:
Medication: Write the name of the medication including dosage (example: 10mg). Describe how and when to take it (example: 1 tablet every morning).
Is child currently taking all medications as prescribed? "No" or "Yes" If answer is "No" give explanation why under summary.
Date Immunization Record Obtained: Date record obtained.
Check box if attached to chart: Check box if immunization record is attached to chart.

Back Page:

Developmental Review:
Does your child have trouble in any of the areas listed? Place an X under "Yes" or "No" for any of the concerns listed.
Is the child difficult to parent? Does parent or guardian feel their child is difficult to parent? Place an X under "Yes" or "No."
Are there any other problems not mentioned above? Is there anything else that needs to be addressed? (anger management, repetitive behaviors, bullying, violent/controlling relationships)

School Information:
Please complete information related to grade, school name, special classes, activities, etc.
Have there been any changes in school performance? (dropping grades, poor attendance, behavior changes, isolation, etc.).
Comments: Place additional comments here

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Health-care Providers:

Please list doctor (nurse practitioner or physician's assistant), eye doctor, dentist, specialist, counselor/psychiatrist/psychologist or other (orthopedist, cardiologist, occupational therapist, physical therapist, dietician, doctor of osteopathy, pastor, etc.).

Date Last Seen: Please list the date of the last visit to the provider.

Additional information:

Have parents or guardians talked to child about: Check all that apply.

- Physical changes (weight gain/loss, development of secondary sex characteristics, breast development, etc.)
- Sexual activities (sex, oral sex, pornography, phone sex, sex parties, abstinence, safer sex, etc.)
- Menstruation (if applicable).
- Methods of birth control (pills, condoms, barrier, etc.)
- Wet dreams (if applicable).
- Sexually transmitted diseases/infections (gonorrhea, Chlamydia, herpes, HIV/AIDS, etc.)

Do parents have any concerns about: Check all that apply:

- Drinking alcohol (self-explanatory)
- School Performance (self-explanatory)
- Drugs (including both over the counter, prescription, illicit, caffeine/energy drinks, cigarettes/tobacco/chew, inhalants, partying)
- Changing Attitudes (self-explanatory)
- Choice of Friends (age appropriate, male and female, unusual behaviors, supervision)
- Peer Pressure (self-explanatory)
- Eating Patterns (anorexia, bulimia, binging, purging, fast food, meal patterns)

Is the child:

- Working (self-explanatory)
- Dating (hanging out, going out)
- Sexually Active (oral, vaginal, anal)
- Using Birth Control (condoms, birth control pills, barriers, abstinence, etc.)
- Self-Mutilation (cutting, branding, piercing, self tattooing, etc.)

Referred to family planning: self-explanatory

Any changes in the family:

- Separation of parent or family member/divorce(self-explanatory)
- Death of a close relative or friend (may include classmate, acquaintance, celebrity)
- Recent move (change of residence including date of relocation)
- Gain of new family member (birth, marriage, step-parent, sibling)
- Loss of job (any loss of job, financial changes for parent, family member or child, if working)

Does the family have someone to call for help in the case of family problems?

Does the child or family have someone to call in case of family problems or emergency? Is there a safety plan?

Summary:

Note areas of concern and issues that need to be addressed. Include positive comments.

Include signature of intake worker (social worker, nurse, outreach, eligibility staff,) and date.

Consent:

Obtain signature of parent or guardian along with witness signature and date.