Sunshine Community Health Center

HC89 Box 8190 ◆ Talkeetna, Alaska 99676 ◆ Mile 4.4 Talkeetna Spur Road ◆ Telephone: (907) 733-2273 ◆ Fax: (907) 733-1735
Willow Clinic: P.O. Box 1049 ◆ Willow, Alaska 99688 ◆ 24091 Long Lake Road ◆ Telephone: (907) 495-4100 ◆ Fax: (907) 495-4106

Patient Name:_____ **Date of Birth:** _____**Today's Date:**_____

Parents' Names:_____ **Child lives with:** _____

Siblings:_____ **Grade:**_____ **School:**_____

Allergies: _____ **Current Medications:** ☐ **None**_____

Birth History: Late

Delivery Type: Breech Breast Fed: No Birth Weight: _____

Substances Used in pregnancy: Prescription:_____
Non-prescription:_____

Did any of the following occur during pregnancy? (Please check)

☐ Fever ☐ Vaginal Bleeding ☐ High Blood Pressure
☐ Diabetes ☐ Alcohol use ☐ Tobacco Use ☐ STDs (Sexually Transmitted Diseases)

Child Health History: (Print form and please circle or check)

- ○ Weakness/swelling
- ○ Excessively tired
- ○ Recurrent Fever
- ○ Weight loss/gain
- ○ Acne
- ○ Bruise easily
- ○ Change in moles
- ○ Scars
- ○ Sores not healing
- ○ Migraines
- ○ Seizures
- ○ Vision problems
- ○ Difficulty hearing
- ○ Ear Infections
- ○ Nosebleeds
- ○ Sinus problems
- ○ Cavities
- ○ Tonsil infections
- ○ Strep throat
- ○ Snoring
- ○ Speech Problems
- ○ Breathing problem
- ○ Tobacco Exposure
- ○ Persistent cough
- ○ Wheezing
- ○ Asthma
- ○ Bronchitis
- ○ Chest pain
- ○ Irregular heart beat
- ○ Heart Murmur
- ○ Heartburn
- ○ Stomach aches
- ○ Persistent Vomiting
- ○ Chronic Constipation
- ○ Blood in stool
- ○ Worms
- ○ Blood in urine
- ○ Frequent urination
- ○ Painful urination
- ○ Bed wetting after 7yr
- ○ Chronic Pain
- ○ Sprains
- ○ Broken bones
- ○ Scoliosis
- ○ Coordination Issues
- ○ Anemia
- ○ Cancer
- ○ Concern of drug use
- ○ Exposure to toxic chemicals
- ○ Excessive Hunger
- ○ Excessive thirst
- ○ Hormone problems
- ○ Chicken Pox
- ○ Measles (10day)
- ○ Measles
- ○ Rubella
- ○ Mumps
- ○ Rheumatic Fever
- ○ Whooping Cough
- ○ Hepatitis Screening
- ○ Hepatitis A
- ○ Hepatitis B
- ○ Hepatitis C
- ○ HIV Screening
- ○ HIV Positive
- ○ Nervousness
- ○ Depression
- ○ Dramatic Mood Swings
- ○ Learning difficulties
- ○ Physical Abuse
- ○ Sexual Abuse

Has anyone in the Childs Family Had: (Print form and please check or circle)

- ○ Skin disease
- ○ Kidney disease
- ○ Alcoholism
- ○ Seizures
- ○ Stomach problems
- ○ Drug Use
- ○ Eye/Ear Problems
- ○ Muscle or bone disease
- ○ Mental Illness
- ○ Allergies
- ○ Sickle cell anemia
- ○ Genetic Problems
- ○ Sinus Problems
- ○ Anemia
- ○ Learning problems
- ○ Heart Problems
- ○ Hemophilia
- ○ HIV/AIDS
- ○ High blood pressure
- ○ Cancer
- ○ Lung Disease
- ○ Thyroid disease
- ○ Asthma
- ○ Diabetes
- ○ Tuberculosis
- ○ Other

Previous Hospitalizations/Surgeries/Illness/Injury: _____

Developmental History (For children under the age of 3)

Please note age of your child when he/she:

Cooed	_____	Walked	_____	Spoon fed	_____
Rolled over	_____	Dressed self	_____	First word	_____
Sat up	_____	Drank from cup	_____	Toilet trained	_____
Stood up	_____	Finger fed	_____		

Do you have firearms at home? No **If yes, are they locked away?** No
Does your home have a working smoke detector? No **Carbon monoxide detector?** No
TV time per day: _____ **Computer and/or gaming time per day:** _____
Does your child always ride in an appropriate car seat for age/weight? No
Are there any stresses in the home that may be of concern? No
If yes, please explain: _____