

CHILD'S NAME:

DATE OF BIRTH:

PREGNANCY AND BIRTH HISTORY

Place of Delivery _____ Delivered by _____

Previous Pregnancies: Total #: _____ Miscarriages _____ Stillbirths _____

Explanation for Miscarriages (if known) _____

Mother's Health During This Pregnancy _____

Labor was Normal / Other (please explain if other than normal) _____

Delivery was Normal / Other (please explain if other than normal) _____

Baby's Birth weight _____ Baby was _____ weeks at delivery Baby was hospitalized for _____ days

Any Illnesses or Complications in the Newborn Period? _____

Did baby or mom require any special diet during pregnancy or newborn period? _____

DEVELOPMENTAL AND MEDICAL HISTORY

At what age (approximately) did your child?

	AGE		AGE
Roll front to back	_____	Have first specific word other	
Roll back to front	_____	than mama or dada	_____
Sit without support	_____	Make a two word sentence	_____
Walk without support	_____	Pedal tricycle	_____
		Dress Self	_____

Does your child have school problems, hyperactivity, learning disabilities, or inattentiveness? Yes / No (please explain) _____

CHILD'S MEDICAL HISTORY:

Has your child ever had:	Yes	No	Please explain if answer is yes to any item
Measles, mumps, or rubella			
Chickenpox			
Whooping Cough (Pertussis)			
Seizures			
Tuberculosis			
Any chronic disease			
Tonsillectomy/Adenoidectomy			
Ear Tubes (PET tubes)			
Bedwetting			
Serious injury or poisoning			
Heart, lung, blood, muscle or Bone disease			
Vision or hearing problems			
Skin problems			
Other			

CHILD'S HOSPITALIZATION HISTORY:

Date	Hospital	How Long Hospitalized	Reason for Hospitalization / Surgery

FAMILY MEDICAL HISTORY:

Does anyone in the family have:	YES	NO	If answer is yes, please explain
Diabetes			
Rheumatoid arthritis			
Anemia, bleeding problems, or leukemia			
High Blood Pressure			
Seizures (Epilepsy)			
Nerve or muscle disorders			
Cystic Fibrosis			
Asthma, allergic rhinitis, or eczema			
Heart murmurs			
Deaths in infancy or of unknown cause			
Kidney or urinary tract problems			
Other			

FAMILY AND HOUSEHOLD

Names of Family Members	Date of Birth	Health problems, school progress, etc.

ALLERGIES AND MEDICATIONS

Does your child use any medications regularly?	Does your child have any allergies (to medications or otherwise)