

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth History**

Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Weight \_\_\_\_\_\_\_lb\_\_\_\_\_oz Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gestational Age \_\_\_\_\_ wks Delivery: \_\_\_ vaginal \_\_\_ caesarian If caesarian, why? \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Discharge \_\_\_\_\_\_\_\_\_\_\_\_

Feeding: Breast \_\_\_\_ Duration \_\_\_\_\_\_\_\_\_\_ Formula(Type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration \_\_\_\_\_\_\_\_\_\_

Any Problems During Pregnancy or after Birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General**

Is your child in good health? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to any medications? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any medical conditions? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any surgeries? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been hospitalized? Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past History** Has your child ever had:

Chickenpox Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Ear Infections Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing or Vision Problems Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma, Bronchitis, or Pneumonia Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seasonal Allergies Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Problems; Snoring Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Headaches Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seizure or Other Neurological Problems Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Skin Problems (eg, eczema, acne) Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bedwetting after 6 years old Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Abdominal Pain Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recurrent Urinary Tract Infections Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Constipation Requiring Doctor Visits Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Problems or Heart Murmur Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia or Bleeding Problem Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Transfusion Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTINUED ON BACK**

Thyroid or Other Endocrine Problems Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Metabolic / Genetic Disorders Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease or Urologic Malformations Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Used Alcohol or Drugs Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Delay Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral Problems or ADHD Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For girls) Problems with periods Yes No Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has had first period Yes No Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other significant medical history\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family Medical History**

Has anyone in the family had:

Asthma Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia, Bleeding Disorder Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bedwetting over 10 yrs old Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Liver Disease Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness / Depression Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Disability Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immune Problems Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug or Alcohol Abuse Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use Yes No Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Family History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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