

 **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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