

MEDICAL HISTORY

DATE _____

NAME _____

BIRTH HISTORY

Birth weight _____ Weeks gestation _____ Vaginal or C/Section? _____

Reason for C/Section _____

Problems during pregnancy _____

Tobacco, alcohol, drug, or medication use during pregnancy _____

Baby's condition after delivery _____

Normal newborn course? _____ Breast or bottle feeding? _____

DEVELOPMENT

At what age did your baby

Smile responsively _____ Babble _____ Roll over _____ Crawl _____ Use pincer grasp _____

Walk _____ Use single words _____ Use word combinations _____ ?

What concerns, if any, do you have about your child's

Physical development _____

Mental or emotional development _____

School performance _____

Behavior _____ ?

PAST MEDICAL HISTORY

Hospitalizations _____

Operations _____

Injuries, accidents _____

Medications _____

Allergies _____

Immunizations – Include copy of current immunization record

Has your child had any of the following? If so, when? Provide details you think are important.

Chickenpox_____

Frequent ear infections_____

Recurrent infections, including strep_____

Hearing problems_____

Vision problems_____

Asthma, bronchitis, pneumonia_____

Environmental/food allergies_____

Heart problem/murmur_____

High blood pressure_____

Anemia/bleeding disorder_____

Abdominal pain_____

Constipation_____

Urinary problems/infections_____

Bedwetting_____

Seizures/neurological problems_____

Skin problems (e.g. acne, eczema) _____

Diabetes_____

Thyroid/endocrine problems_____

Menses (onset date, problems)_____

Tuberculosis, positive TB skin test_____

Drug/alcohol use_____

Any other significant problem_____

Specialists, including dentists and eye doctors _____

FAMILY HISTORY

Which family members have had the following condition(s):

Diabetes _____ Cancer _____

Heart disease _____ High blood pressure _____

High cholesterol _____ Anemia/bleeding disorder _____

Asthma _____ Allergies _____

Kidney disease _____ Gastrointestinal problems _____

Liver problems _____ Deafness _____

Mental illness _____ Drug/alcohol problems _____

Other _____ ?

SOCIAL HISTORY

Names and dates of birth of your child's brothers and sisters:

_____	_____
_____	_____
_____	_____
_____	_____

With whom does your child live? _____

Describe any tobacco exposure _____

What school or day care does your child attend? _____

Your child's special interests: _____

Any other information you would like to include: _____
