

## MEDICAL HISTORY

Patient's Name (Last, First, Middle) \_\_\_\_\_

Date of Birth \_\_\_\_\_

Today's date \_\_\_\_\_

## PREGNANCY AND BIRTH

Did you have prenatal care?  Yes  No When was your first prenatal visit? \_\_\_\_\_

Did you have any illnesses or problems during your pregnancy? (explain) \_\_\_\_\_

Was your delivery *vaginal* or *caesarean*? (please circle) How many weeks gestation? \_\_\_\_\_

In what hospital was your baby born? \_\_\_\_\_ Baby's birth weight? \_\_\_\_\_

Did your baby have any problems at birth or in the nursery?  Yes  No. If yes, please describe \_\_\_\_\_

Please circle if your baby needed:

Oxygen: How long? \_\_\_\_\_

Medications: Name? \_\_\_\_\_

How long? \_\_\_\_\_

IV Fluids: Name? \_\_\_\_\_

How long? \_\_\_\_\_

Jaundice: Under *lights* or *light blanket*? (please circle)

How long? \_\_\_\_\_

Transfusion: When? \_\_\_\_\_

How many times? \_\_\_\_\_

Other: \_\_\_\_\_

## DIET AND NUTRITION

Was your baby *breast* or *formula* fed? (please circle) How long breast fed? \_\_\_\_\_ Type of formula \_\_\_\_\_

What is your child's present diet? \_\_\_\_\_

Any problems with diarrhea or constipation? (please describe) \_\_\_\_\_

Is your child on fluoride or vitamins?  Yes  No What Brand? \_\_\_\_\_

## MEDICAL

Has your child ever been in the hospital overnight?  Yes  No

If yes, at what age? \_\_\_\_\_ What hospital? \_\_\_\_\_ What problem? \_\_\_\_\_

Has your child ever had surgery? If yes, please explain \_\_\_\_\_

Has your child ever broken a bone? If yes, please explain \_\_\_\_\_

Does your child take any medications on a regular/daily basis? If yes, please explain \_\_\_\_\_

Please circle if your has any of the following conditions and give details below:

*Asthma*

*Allergies/Hayfever*

*Eczema*

*Hearing Loss*

*Eye Problems*

*Arthritis*

*Heart Disease*

*Tuberculosis*

*Kidney Disease*

*Seizures*

*Anemia*

*Bone/Joint Problems*

Has your child had chickenpox?  Yes  No Date or age \_\_\_\_\_

Has your child had frequent sore throats or strep?  Yes  No

Has your child had frequent ear infections?  Yes  No

## FAMILY HISTORY

Please list any family members, including parents, grandparents and siblings, who have any of the following:

|                                  |  |
|----------------------------------|--|
| Diabetes _____                   | Genetic Disorders (Down's, M.D.) _____ |
| Heart Disease/Heart Attack _____ | Cancer _____                           |
| High Blood Pressure _____        | Stomach/Bowel Problems _____           |
| Seizures/Epilepsy _____          | Alcoholism _____                       |
| Allergies/Asthma _____           | Drug Abuse _____                       |
| Obesity _____                    | Smoking _____                          |
| Kidney Bladder Problems _____    | Sickle Cell _____                      |
| Mother's Age _____ Health _____  | Sibling's Age _____ Health _____       |
| Father's Age _____ Health _____  | Sibling's Age _____ Health _____       |
| Sibling's Age _____ Health _____ | Sibling's Age _____ Health _____       |

## ALLERGIES

Please list any medications your child is allergic to: \_\_\_\_\_

Please list any foods your child is allergic to: \_\_\_\_\_

Is your child allergic to bee stings or pollens? (please circle) List other allergies \_\_\_\_\_

Does anyone smoke the child's home? \_\_\_\_ Yes \_\_\_\_ No Are there pets in the child's home? \_\_\_\_ Yes \_\_\_\_ No

What is the age of the child's house/apartment? \_\_\_\_\_ Has it been checked for lead? \_\_\_\_\_

## GENERAL

Do you have any concerns about your child's development? \_\_\_\_ Yes \_\_\_\_ No

Do you have any concerns regarding your child's behavior? \_\_\_\_ Yes \_\_\_\_ No

Does your child have any sleep or discipline problems? \_\_\_\_ Yes \_\_\_\_ No

## SCHOOL/EDUCATION

What grade is your child in? \_\_\_\_\_

Is your child having any problems with learning? \_\_\_\_ Yes \_\_\_\_ No

Is your child having any problems getting along with other child? \_\_\_\_ Yes \_\_\_\_ No

Is your child receiving special help or tutoring in school? \_\_\_\_ Yes \_\_\_\_ No

## SAFETY

Do you have a car seat for your infant or toddler, or does your older child use a seat belt? \_\_\_\_ Yes \_\_\_\_ No

When riding a bicycle, does your child wear a bike helmet? \_\_\_\_ Yes \_\_\_\_ No

If you have an infant/toddler, is your home child-proof? \_\_\_\_ Yes \_\_\_\_ No

If you have a toddler, do you have Ipecac Syrup at home? \_\_\_\_ Yes \_\_\_\_ No

Do you have important emergency phone numbers listed near your phone for immediate reference? \_\_\_\_ Yes \_\_\_\_ No

Do you have any questions or concerns today? \_\_\_\_\_

Is there anything special your want to review today? \_\_\_\_\_

Please print your name \_\_\_\_\_

Your relationship to the child \_\_\_\_\_

**MEDICAL HISTORY**

Today's date \_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_  
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**PREGNANCY AND BIRTH**

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Was your delivery *vaginal* or *caesarean*? (please circle)  
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How many weeks gestation?  
\_\_\_\_\_

In what hospital was your baby born? \_\_\_\_\_

Baby's birth weight? \_\_\_\_\_

Did your baby have any problems at birth or in the nursery? \_\_\_\_ Yes \_\_\_\_ No. If yes, please describe  
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Please circle if your baby needed:

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**DIET AND NUTRITION**

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**MEDICAL**

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