

## MEDICAL HISTORY

Today's date

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

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

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### 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: \_\_\_\_\_

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### 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? \_\_\_\_\_

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### MEDICAL

Has your child even 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  
\_\_\_\_\_

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

**Asthma**  
**Hearing Loss**  
**Heart Disease**  
**Seizures**

**Allergies/Hayfever**  
**Eye Problems**  
**Tuberculosis**  
**Anemia**

**Eczema**  
**Arthritis**  
**Kidney Disease**  
**Bone/Joint Problems**

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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 _____

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## **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?

\_\_\_\_\_

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## **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

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## **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

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## **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

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Do you have any questions or concerns today?

\_\_\_\_\_

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Is there anything special you want to review today?

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

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