

PETER Y. JUNG, M.D., F.A.A.P · WILLIAM C. PIELOP, M.D., F.A.A.P.
 SECILY W. TORN, M.D., F.A.A.P. · AMANDA W. BRACK, M.D., F.A.A.P. · JILL M. EDDINGS, M.D., F.A.A.P.

Patient Name: _____ **Completed by:** _____ **Relation:** _____
 Please check yes or no, circle, or ✓ where required. N/A – Not Applicable

Previous medical care – Dr.

PREGNANCY & BIRTH		Mother's age at pregnancy?	FAMILY MEDICAL HISTORY					
Any illnesses during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO			List all blood relatives of your child who have had the following problems – use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin					
Medication during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO (exclude vitamins & iron)			Anemia/Blood Dis					
<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Street drugs – during pregnancy?			Asthma					
Which hospital did you deliver at?			Mental Retardation					
At birth, how many gestational weeks old was your child? (e.g. term = 40 weeks)			Drug Problem					
Type of delivery?	Birth Weight:	Length:	Alcoholism					
Complications? <input type="checkbox"/> YES <input type="checkbox"/> NO		Apgar:	Cancer					
Problems with baby at birth? Breathing: <input type="checkbox"/> YES <input type="checkbox"/> NO Jaundice: <input type="checkbox"/> YES <input type="checkbox"/> NO			Aids					
Pass Hearing Screen? <input type="checkbox"/> YES <input type="checkbox"/> NO		Mother's Blood Type:	Cystic Fibrosis					
Were you ever told baby was breech in the third (3 rd) trimester? <input type="checkbox"/> YES <input type="checkbox"/> NO			Musc. Dystrophy					
PAST MEDICAL HISTORY		Allergic reactions? Medicine: <input type="checkbox"/> YES <input type="checkbox"/> NO	Tuberculosis					
Food: <input type="checkbox"/> YES <input type="checkbox"/> NO Animals: <input type="checkbox"/> YES <input type="checkbox"/> NO Insect Bites: <input type="checkbox"/> YES <input type="checkbox"/> NO			Arthritis					
Medications taken on a regular basis? (exclude vitamins)			Epilepsy / Seizures					
Immunizations – up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have records? <input type="checkbox"/> YES <input type="checkbox"/> NO			Heart Disease					
Hospitalizations – (when-where-why?)			High Blood Pressure					
Surgeries (when-where?)			Cholesterol Problem					
	YES	NO	YES	NO	YES	NO	Migraine	
Red Measles	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	German Measles (3 day)	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/Hives	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Problems with hearing	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Infections	<input type="checkbox"/>	<input type="checkbox"/>	Problems with vision	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
FEEDING & NUTRITION		Food Allergies	DEVELOPMENT & BEHAVIOR					
Appetite usually good? <input type="checkbox"/> YES <input type="checkbox"/> NO			Age at which child					
Colic or feeding problems during the first 3 months? <input type="checkbox"/> YES <input type="checkbox"/> NO			Sat alone: Walked: Used sentences:					
Breast fed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of months?		Toilet trained: Bicycled:					
Formula? <input type="checkbox"/> YES <input type="checkbox"/> NO	Current brand?		Development compared to other children?					
Vitamins? <input type="checkbox"/> YES <input type="checkbox"/> NO	Brand?	Flouride? <input type="checkbox"/> YES <input type="checkbox"/> NO	Grade in school:					
			Problems in school? <input type="checkbox"/> YES <input type="checkbox"/> NO					
FAMILY PROFILE		Parents <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Learning problems? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Father's Age?	Highest school grade?	Health?	Getting along with other children? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Mother's Age?	Highest school grade?	Health?	Behavior problems? <input type="checkbox"/> YES <input type="checkbox"/> NO					
(List child's brothers, sisters, and their ages)			Bad Habits? <input type="checkbox"/> YES <input type="checkbox"/> NO					
			Bedwetting? <input type="checkbox"/> YES <input type="checkbox"/> NO					
			Nail biting? <input type="checkbox"/> YES <input type="checkbox"/> NO					
			Sleeping? <input type="checkbox"/> YES <input type="checkbox"/> NO					
			Hobbies / sports?					
			Use of street or illegal drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO					
SYNOPSIS								