

**Patient Name:** \_\_\_\_\_ **Completed by:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

\*\*\*Previous Medical Clinic: Dr. \_\_\_\_\_

<b>PREGNANCY &amp; BIRTH</b>		Mother's age at pregnancy?	<b>FAMILY MEDICAL HISTORY</b>					
Any illnesses during pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO			<i>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</i>					
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					
At birth, how many gestational weeks old was your child? (e.g. term = 40 weeks)			Mental Retardation					
Type of delivery?	Birth Weight:	Breech?:	Drug Problem					
Complications? <input type="checkbox"/> YES <input type="checkbox"/> NO		Apgar:	Alcoholism					
Problems with baby at birth? Breathing: <input type="checkbox"/> YES <input type="checkbox"/> NO Jaundice: <input type="checkbox"/> YES <input type="checkbox"/> NO			Cancer					
Other:			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 <sup>rd</sup> ) trimester? <input type="checkbox"/> YES <input type="checkbox"/> NO			Musc. Dystrophy					
<b>PAST MEDICAL HISTORY</b>		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		
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"/>
<b>FEEDING &amp; NUTRITION</b>		Food Allergies	<b>DEVELOPMENT &amp; BEHAVIOR</b>					
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					
<b>FAMILY PROFILE</b>		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					
<b>SYNOPSIS</b>								