

Name _____ Birth date _____

FAMILY HISTORY

	Date of Birth	Ht.	Wt.	Medical Problems	Educational Level
MOTHER					
FATHER					

Is there a family history of any of the following (include child's parents, siblings, grandparents, aunts and uncles)?

Please check yes or no to all questions.

Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Birth Defects	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding tendencies	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma/Wheezing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lazy Eye	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thyroid disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Early Heart Attacks	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mental Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Emotional Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hip Disorders in Infancy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Other Illnesses	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered yes to any of the above, please explain _____

SOCIAL HISTORY

Do you and your family have a religious preference? Yes No If yes, please specify: _____

Marital status of parents: Married Single

Has there been a separation, divorce or death? Specify _____

What has been the attitude of your child to this situation? _____

Have you or anyone in your family used any alternative forms of therapy such as chiropractic, homeopathy, megavitamins, acupuncture or herbal medicine? Yes No Please specify _____

Is there a gun in your home? Yes No

Are there pets in your home? Yes No

Does anyone in your home smoke? Yes No

Are there financial problems in the family? Yes No

Are there family disagreements on how to raise this child? Yes No

With whom does the patient live? (List all household members and their relationship to patient.) _____

(Over)



PREGNANCY HISTORY WITH THIS CHILD

Have you had breast surgery? Yes No
 Did you take hormones during pregnancy? Yes No
 Did you take any drugs during pregnancy? Yes No
 Did you smoke during pregnancy? Yes No
 Did you drink any alcoholic beverages during pregnancy? Yes No
 Has the child's mother had any miscarriages, still births, or abortions? Yes No If yes, please list _____

BIRTH HISTORY OF CHILD

Circle one: Full term pregnancy _____ Premature birth at _____ weeks Adopted - At what age? _____
 Has he/she been told he's adopted? Yes No Where was child born? _____
 Type of delivery _____ Obstetrician _____
 Birth weight _____ Length _____ Head circ. _____ Apgars _____
 Circle one: Breast fed _____ Bottle fed _____
 Any problems at birth? Please specify _____

CHILD'S DEVELOPMENT

Please list age of child when the following milestones were reached
 Sat alone at _____ mos. Walked at _____ mos. Words at _____ mos. Sentences at _____ mos.
 First teeth at _____ mos. Bladder trained at _____ mos. Bowel trained at _____ mos.
 Does the child have any handicap? Yes No Please specify _____
 Is there a bed-wetting problem? Yes No Is there a family history of bed-wetting? Yes No

SCHOOL PERFORMANCE

Scholastic performance: Academic _____
 Behavior _____
 Has child ever been in a special education class? Yes No
 Has the child had a learning problem? Yes No
 If yes, what type of learning problem? _____

PAST ILLNESSES

Please mark date or frequency of illness or specify substance causing allergy.
 Roseola _____ Asthma _____ Rubella (German measles) _____
 Chicken Pox _____ Heart Murmur _____ Allergic to Medication _____
 Mumps _____ Colds _____ Allergic to Foods _____
 Tonsillitis _____ Scarlet fever _____ Allergic to Insect Bites _____
 Pneumonia _____ Ear infections _____ Has he/she received desensitization shots? Yes No
 Convulsions _____ Urinary infections _____ Other _____

OPERATIONS AND HOSPITALIZATIONS

Please specify date or reason.
 Appendectomy _____ Tonsils and Adenoids _____ Ear tubes _____
 Other operations _____
 Other hospitalizations _____

MEDICATIONS

Is you child taking any medication on a regular basis? Yes No
 Please specify _____

CHILD'S PREVIOUS PEDIATRICIAN

Name _____ Phone# (_____) _____

ANYTHING ELSE ABOUT YOUR CHILD?

Is there anything else about your child you feel we need to know to provide the best medical care for him/her?
 Please specify _____

Name of person completing this form _____

You have completed the questionnaire. Please return to the front office so your doctor can review this information before your child's examination. Thank you.

