Medical History

Today's date _____ Date of Birth _____

Your Child's Name Is: _____ How old is your child? _____

Was your child born: Early / Term (on time) / Late (Please circle one.)
How many weeks pregnant was your child's mother when your child was born? _____ weeks.
Born at what hospital? _____ How was your child delivered? Vaginal / C-section. (Please circle one.)
Any problems with you or your child around the birth?

Does your child have any allergies? _____

Where does your child get immunizations? _____ Are they Up-to-Date? Yes / No

Does your child have any medical problems or long-term illnesses? What kind?

Has your child had chicken pox?

Does your child take any medicines on a regular basis? If so, what medicine?

Has your child been in the hospital over night? If so, for what reason? When? Date?

Any surgeries? Any major injuries? If so, what kind?

Developmental History

Do you have any concerns about your child's development? If so, what concern?

At what age did your child: Roll over? _____ Sit alone? _____ Walk? _____ Talk? _____

Social History

In what city does your child live? _____
Who does your child live with? Mother / Father / Step-mom / Step-dad / Grandmother / Grandfather (Please circle.)

How many brothers and sisters live with your child? (Please write the number in the space.)

full-sibs: ___ (male) and ___ (female), half-sibs: ___ (male) and ___ (female), &/or step-sibs: ___ (male) and ___ (female).
Does anyone else live with your child? Who?
Any brothers or sisters live somewhere else?

Guns in home ____ Guns are locked up and kept separate from ammunition ____

Does your child live with anyone who smokes? Yes / No
Does your child have any pets? Yes / No If so, what kind? _____
Is your child in daycare? Yes / No Do you have city water? Yes / No

Family History

Your child's mother's age: _____ Your child's father's age: _____
Do any of your child's relatives have these problems (ONLY mother, father, brothers/sisters, grandparents, aunts, uncles, first cousins)?
Who? (Please write who in the space next to the problem.)

Allergies	Ear Disorders	Kidney Problems
Bleeding Disorders	Diabetes	Mental Illness
Arthritis	Thyroid Problems	Stomach Problems
Asthma	Hearing Problems	Neurological
Birth Defects	Liver Disorder	Seizures
Cancer	High Blood Pressure	Tuberculosis
Cystic Fibrosis	High Cholesterol	ADHD/ADD
Developmental Disorders	Bed wetting (after age 10y)	Vision impairment / eye disorder
Drug abuse	Alcohol abuse	Immune problems / recurrent
Infections or HIC/AIDS		
Other		