CHILD'S NAME___________________________DATE OF BIRTH______

PREGNANCY and BIRTH HISTORY

Place of Delivery_________________________Delivered by______________________
Previous Pregnancies Total#_____ Miscarriages #_______ Stillbirth #__________
Explanation for Miscarriages (if known)____
Mother's Health during this Pregnancy____
Labor was NORMAL OTHER (Explain if OTHER)___________________________
Delivery was NORMAL OTHER (Explain if OTHER)_________________________
Baby was _____weeks at delivery BIRTH WEIGHT_____ In Hopital for _______days
Any complications for Mom Or Baby?____
How did you hear about our office?____

FAMILY AND HOUSEHOLD		
Names of Family Members	Date of Birth	Occupation, Health problems, School progress, etc

Any smokers at home?_________ Any pets?_______________________________________

FAMILY HISTORY			
DOES ANYONE IN THE FAMILY HAVE?	**NO**	**YES**	If answer is YES, please list relative. Include only relatives related to child by blood.
Asthma			
Allergies			
Anemia			
Bleeding Problems			
Cancer			
High Blood Pressure			
High Cholesterol			
Strokes			
Heart attacks			Age
Heart murmur			
Diabetes			Age of onset
Seizure Disorder			
Chronic Skin Disease			
Nerve or muscle disorders			
Learning or Behavior problems			
Other			