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?_______________________________________

CHILD'S MEDICAL HISTORY:

Has your child ever had?	**NO**	**YES**	Please explain if answered yes
Broken bones			
Seizures			
Recurrent Ear Infections			
Pneumonia			
Asthma			
Allergies			
Heart problems			
Skin Problems			
Kidney infections			
Easy bruising or bleeding			
Vision problems			
Hearing problems			
Behavior problems			
Learning problems			
Serious illnesses			
Serious injuries			

CHILD'S HOSPITALIZATION AND SURGICAL HISTORY:

DATE	HOSPITAL	HOW LONG IN HOSPITAL	REASON FOR HOSPITALIZATION OR SURGERY

ALLERGIES AND MEDICATIONS	
Does your child use any medications regularly?	Is your child allergic to anything?

Are there any other concerns that you would like us to know about your child or family?
____
____
____

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			
Cancer			
Bleeding Problems			
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			