NAME: _____ DATE OF BIRTH: _____

BIRTH AND DEVELOPMENT HISTORY

Problems with pregnancy? _____
What was child gestational age? _____
Birth weight: _____ Birth length: _____
Hospital where born _____
Type of delivery and problems _____

At what age did child:
Smile _____ Roll Over _____
Sit alone _____ Walk _____
Talk _____ Other _____
Toilet Train _____

PAST MEDICAL HISTORY

Has your child:

Had a serious illness? ☐ Yes ☐ No

Ever been hospitalized? ☐ Yes ☐ No

Ever had surgery? ☐ Yes ☐ No

Ever had a major injury? ☐ Yes ☐ No

Is your child taking any medications? ☐ Yes ☐ No

Does your child have any allergies? ☐ Yes ☐ No

Explain any "Yes" answers:_____
_____

Has your child had:

☐ Measles ☐ Chicken Pox ☐ Mumps ☐ Meningitis ☐ Other_____

CURRENT PROBLEMS

☐ Asthma
☐ Bed Wetting
☐ Frequent Tonsillitis
☐ Ear Infections
☐ Hearing Problems
☐ Diabetes
☐ Bowel Problems
☐ Drug Use
☐ Bladder / Kidney Problems
☐ Sickle Cell Disease/Trait
☐ Other _____

☐ Anemia
☐ Vision Difficulty
☐ Heart Problems
☐ Breathing Problems
☐ Eye Problems
☐ Seizures
☐ Tobacco Use
☐ Alcohol Use

FAMILY MEDICAL HISTORY

Key: F (father) M (mother) FP (father's parents)
MP (mother's parents) S (siblings) PS (parent's siblings

	F	M	PS	FP	S	MP
High Blood Pressure						
Allergies/Asthma						
Stroke						
Hepatitis						
Heart Problems						
Anemia						
Cancer						
Diabetes						
TB/Lung Problems						
Kidney Disease						
Genetic Disorders						
Sickle Cell						
Alcohol/Drug Use						
Mental/Nerve disorder						

Date Obtained or Updated	Signature	Area where changes noted