CHILD'S HISTORY:

NAME:_____
LAST FIRST M.I.

DOB:_____ SEX _____

NEWBORN HISTORY

GESTATIONAL AGE _____ TYPE OF DELIVERY: ☐ VAGINAL ☐ C-SECTION

HOSPITAL: _____ OB/MIDWIFE: _____

BIRTH WEIGHT: _____ DISCHARGE WEIGHT: _____ TIME OF BIRTH ____

APGARS: _____ BLOOD TYPE: _____ MOM'S BLOOD TYPE: _____

HEARING SCREEN: ☐ PASS ☐ REFER NEWBORN SCREEN ID #_____

COMPLICATIONS/HOSPITAL COURSE:

_____

_____

MEDICAL HISTORY:

DATE OF LAST CHECK-UP: _____ PREVIOUS MD: _____

HAS CHILD EVER HAD ANY OF THE FOLLOWING?:

__ ANEMIA
__ ARTHRITIS
__ ASTHMA
__ CHEMICAL DEPENDENCIES
__ DIABETES
__ DIARRHEA / CONSTIPATION
__ EAR INFECTION
HOW MANY?_____
__ EATING DISORDER
__ EPILEPSY/SEIZURES
__ EXCESSIVE BLEEDING
__ FRACTURES
__ HEADACHES/DIZZINESS
__ HEART MURMUR
__ JAUNDICE
__ REFLUX
__ RHEUMATIC FEVER
__ URINARY TRACT INFECTION
__ VARICELLA (CHICKEN POX)
__ OTHER

_____

_____

REFERRALS: PLEASE LIST ANY SPECIALTY DOCTORS INVOLVED IN YOUR CHILD' CARE:
NAME SPECIALTY PROBLEM

_____

PAST SURGICAL HISTORY/HOSPITALIZATIONS: ☐NONE
PROCEDURE/ILLNESS HOSPITAL YEAR

_____

_____

MEDICATIONS: ☐NONE

_____

_____

ALLERGIES: ☐NONE

_____

_____

SOCIAL HISTORY:

DOES CHILD ATTEND DAYCARE/SCHOOL?: ☐NO ☐YES_____

GRADE? _____ PERFORMANCE: _____

WHO LIVES AT HOME?:_____

SEATBELTS/BOOSTER SEATS USED EVERYTIME CHILD IS IN A CAR? ☐NO ☐YES

ARE THERE GUNS IN THE HOME? ☐NO ☐YES

DEVELOPMENT:

PLEASE TRY TO ESTIMATE THE AGE AT WHICH YOUR CHILD WAS ABLE TO DO THE FOLLOWING THINGS

SAT ALONE_____ WALKED ALONE _____SPOKE FIRST WORD _____ SPOKE SEVERAL WORDS _____