PATIENT'S NAME_______________________________

PATIENT'S BIRTHDATE__________________________

PATIENT AND FAMILY HISTORY

Circle One

A. PREGNANCY & BIRTH

1. Did the mother have any illness or take any medication during pregnancy? Y N

   List: ____

   ____

2. Did the mother have a difficult delivery? Y N
3. Was the baby born early, late or at term? Y N
4. Were there any medical concerns with the baby at birth? Y N
5. What was the baby's birth weight? ______________
6. Did the baby remain in the hospital after the mother was discharged? Y N
7. Was there any Jaundice, blueness or convulsions in the newborn period? Y N

B. FAMILY HISTORY

1. Circle any of the following that the child's parents, grandparents, aunts, uncles, brothers or sisters have had. Indicate relationship.

   Tuberculosis __________________ Diabetes __________________

   Seizures __________________ Mental Illness __________________

   Kidney Disease __________________ Blood Disease __________________

   Anemia ___________________ Heart Disease __________________

   Cancer ___________________ Hypertension ___________________

   Allergies (Hay fever, Asthma, Eczema) ________________________________

   Inherited or Congenital disease ________________________________

2. List ages, sex and general health of brothers and sisters

   ____

   ____

   ____

C. **ALLERGIES**

1. Has your child ever had eczema or hives? Y N
2. Has your child ever had wheezing or asthma? Y N
3. Does your child have a constant stuffy or runny nose? Y N
4. Has your child had any reaction to food or medicine? Y N

   List: ____

   ____

D. **FEEDING & DIGESTION**

1. Are there any feeding difficulties? Y N
2. Does your child have any problems with constipation, diarrhea or vomiting? Y N
3. Does your child eat paint chips, dirt or any other nonfood items? Y N
4. Is there any blood or mucus on the bowel movements? Y N
5. Does your child have FREQUENT abdominal pain? Y N
6. Was it ever necessary to change formula or put your child on a special diet? Y N

E. **INFECTIONS, ILLNESS, DEVELOPMENT AND MISCELLANEOUS PROBLEMS**

1. Does your child have as many as three bouts of ear trouble a year? Y N
2. Does your child have more than four colds and/or sore throats per year? Y N
3. Has your child had or have a history of bladder or kidney problems? Y N
4. Has your child ever had a convulsion? Y N
5. Has your child ever had any adverse reactions to vaccines? Y N
6. Any history of chronic medical problems (asthma, allergies, etc.) Y N

   List:____

7. Has your child ever had surgery? If yes, what procedure/date _________________ Y N

   ____

8. Any hospitalizations? If yes, reason/date ___________________________________ Y N
9. Did your child begin speaking after age two? Y N
10. Do you feel there is a problem with vision or hearing? Y N

11. Does your child take medication on a regular basis? Y N

If yes, what medication and for what condition?

List: ____

____

F. **EMOTIONAL PROBLEMS**

1. Does your child have any problems in school? Y N

   If yes, emotional or scholastic? (Circle one)

2. Does your child have any difficulty playing or making friends in his/her age group? Y N

Parent Signature____

Date ___________________________