**NAME**______________________________________________**M**____**F**____ **DOB:**________________________

## PAST MEDICAL HISTORY

**Allergic Reaction:**

Medicine ________________________

Food ___________________________

Insect___________________________

Other ___________________________

Are immunizations up-to-date? __________

**Hospitalizations:**

1. Date/Age: ____________________________________
   Hosp: ________________________________________
   Dx/Tx: _______________________________________
2. Date/Age: ____________________________________
   Hosp: ________________________________________
   Dx/Tx: _______________________________________

**Immunization Record**

| | | | | | |
|---|---|---|---|---|---|
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Any physical or mental handicap? ________________________________________________________________

Seizures ___________________________________

Bleeding Tendency ___________________________

Recurrent Ear Problems _______________________

Chicken Pox ________________________________

Measles ____________________________________

Pulmonary or cardiac disorder __________________

STD _______________________________________

Arthritis ____________________________________

Bed Wetting _________________________________

Scarlet Fever ______________________________

Rheumatic Fever ______________

Hearing Problems _____________

Eczema _____________________

Asthma _____________________

GU Infections _________________

Menstrual Problems ____________

School problems _______________

Is your child taking any regular medication? _______

Has Development been normal? _________________________________________________________________

Sat alone _______________ Walked ________________ Sentences ___________________

Fed Self ________________ Peer Problems __________ Grade Failure _________________

NAME ______________________________________M___F___ DOB ___________________________

## BIRTH HISTORY

Gestational Age ________________

Delivery Weight _______________

Type of Delivery _______________

Apgar Score __________________

PROBLEMS/COMPLICATIONS:

NEONATAL

Infection ____________________

Jaundice ____________________

Circumcision ________________

Other ______________________

PREGNANCY

Drugs ______________________

Alcohol _____________________

Medication __________________

Problems ___________________

NEWBORN SCREEN

Galactosemia ________________

PKU _______________________

_____________________________________________________

CAH _______________________

_____________________________________________________

SICKLE ____________________

_____________________________________________________

THYROID __________________

_____________________________________________________

FEEDING

Breast _______ How Long? _______

Formula _______________________ Water Supply ____________________

## FAMILY HISTORY

Mother _______________________Age _____Health ________

Father ______________________ _Age _____Health ________

Siblings:

1. ____________________________Age _____Health _______
2. ____________________________Age ___ _ Health _______
3. ____________________________Age ___ _ Health _______
4. ____________________________Age ___ _ Health _______

Heart Attack/Stroke ________ Muscular Dystrophy ______

Asthma/Eczema/Hay Fever ____ Diabetes _________________

Bleeding Disorder ____________ Seizures _________________

Congenital Heart Disease ______ Arthritis _________________

Cancer ______________________ Tuberculosis ______________

Anemia ____________________ Sickle Cell ________________

Cystic Fibrosis ______________ SIDS ____________________

Mental Retardation__________ GI Disorder ______________

Migraine ___________________ Deafness _________________

Hypertension ________________ AIDS ____________________

Alcoholism/Depression ___________________________________

Other _____________________________________________________