HISTORY FORM

A. Pregnancy and Birth

1. What hospital did you have your baby? ____________________________
2. How many pregnancies? _________ Any miscarriages? ______________
3. Did you have any illnesses during your pregnancy? __________________
4. Did you have any bleeding during your pregnancy? _____
   If so, during ________ months
5. What is your blood type? __________________
6. Did your baby come on time? ________
   Early_____ Late_____ If so how much_______________________
7. Birth weight _______________ Length____________________________
8. Did your baby have any problems in the hospital with:
   Breathing_________________ Jaundice_____________________
   Infection_________________ Convulsions__________________

B. Feeding and Digestion

1. Were there any feeding problems in the first three months? Yes No
2. Did your child have colic? Yes No
3. Is your child's appetite usually good? Yes No
4. Do any foods disagree with him/her? Yes No
5. Has your child ever had diarrhea? Yes No
6. Has constipation ever been a problem? Yes No
7. If on vitamins, what kind and how much? ___________________________
8. Are you currently breast feeding or did you? ________________________
9. If on formula,, which one do you use? _____________________________

C. Family History

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:
   Seizures, Diabetes, Tuberculosis, Asthma, Eczema, Allergies, Nervous Breakdowns, Hypertension (High Blood Pressure), Rheumatic Fever, Rheumatoid Arthritis, Coronary Artery Disease (Heart Attack under age 50), Addictive Disorders (Drug, Alcohol, Gambling, Etc.)
2. Are the child's parents both in good health? Yes No
3. Mothers age ___________ Fathers age _______________
4. List ages, sex, name and general health of siblings of this child:
   ____
   ____
5. Have any of your children died? Yes No
6. If your child is adopted, do you have any information regarding their health?
   ____

Has your child:

1. Had as many as three attacks of ear trouble in a year Yes No
2. Had more than 3 upper respiratory infections w/ fever in a year? Yes No
3. Had any trouble with urination? Yes No
4. Ever had a seizure? Yes No
5. Had any trouble with hearing? Yes No
6. Had any trouble with vision? Yes No
7. At what age did your child:
   a. sit alone ____________
   b. stand alone ____________
   c. walk alone ____________
   d. said words ____________
   e. said sentences____________
8. Does your child have any dental problems? Yes No

E. Circle any of the following that your child has had:

Chickenpox	Influenza
RSV	RotaVirus
Heart Murmur	Kidney or Bladder Infection
Serious Accidents	Chronic Diarrhea
Pneumonia	Broken Bones

F. Hospitalizations:

Removal of Tonsils and/or Adenoids ______________________________

Repair of Hernia ______________________________

Other operations ______________________________

Illnesses ______________________________

G. Allergies

Has your child ever had?

1. Eczema or hives?
2. Wheezing or Asthma?
3. Does he/she tend to have a stuffy nose or constant cold?
4. Circle any medications to which he/she has had an adverse reaction:

Penicillin	Sulfa	Other Antibiotics
Codeine	Novocain	

H. Behavior

Does your child:

1. Have any school problems? Yes No
2. Get along well with other children? Yes No