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Health History

1. Birth History

Hospital:

Birth Time:

Birth Weight:

Gestational Age:

Length:

Delivery:

☐ vaginal ☐ caesarian

Date of Discharge:

If caesarian, why?

Feeding:

☐ Breast ☐ Formula

Duration:

Type:

Duration:

Any problems during pregnancy or after birth?

☐ Yes ☐ No

If so, please specify:

2. General

	Yes	No	Explain
Is your child in good health?			
Is your child allergic to any medications?			
Does your child have any medical conditions?			
Has your child had any surgeries?			
Has your child been hospitalized?			

3.

	Current Medications
1	
2	
3	

Past History

4. Has your child ever had:

	Yes	No	Explain
Chickenpox			
Frequent Ear Infections			
Hearing or Vision Problems			
Asthma, Bronchitis, or Pneumonia			
Seasonal Allergies			
Sleep Problems; Snoring			
Frequent Headaches			
Seizure or Other Neurological Problems			
Chronic Skin Problems (eg, eczema, acne)			
Bedwetting after 6 years old			
Frequent Abdominal Pain			
Recurrent Urinary Tract Infections			
Constipation Requiring Doctor Visits			
Heart Problems or Heart Murmur			
Anemia or Bleeding Problem			
Blood Transfusion			
Obesity			
Diabetes			
Thyroid or Other Endocrine Problems			
High Blood Pressure			
Cancer			
Metabolic / Genetic Disorders			
Kidney Disease or Urologic Malformations			
Used Alcohol or Drugs			
Developmental Delay			
Behavioral Problems or ADHD			
Other significant medical history			

5. (For girls)

	Yes	No	Explain
Problems with periods			
Has had first period			

Family Medical History

6.		Yes	No	Who?	Comments
	Asthma				
	Diabetes				
	Epilepsy				
	Cancer				
	Tuberculosis				
	Heart Disease				
	High Blood Pressure				
	High Cholesterol				
	Tuberculosis				
	Anemia, Bleeding Disorder				
	Bedwetting over 10 yrs old				
	Kidney Disease				
	Liver Disease				
	Mental Illness / Depression				
	Developmental Disability				
	Immune Problems				
	Drug or Alcohol Abuse				
	Tobacco Use				

7. Additional Family History:
