

NAME _____ DOB _____ EXAM DATE _____ SEX _____

PARENT'S FULL NAME _____

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PRENATAL / BIRTH HISTORY

Method of Delivery Labor Length
 Gestational Age
 Birth Weight
 APGAR Scores
 G ___ P ___ (# of pregnancies / # of living children)
 Child's Blood Type
 Complications
 Jaundice
 Phototherapy Duration
 Time of Birth Place of Birth
 Age of Mother Maternal Blood Type ___ Rh___
 Maternal Medication Use
 Maternal Smoking/Drug Use
 Breastfed/Bottle-fed Number of Months

PAST MEDICAL HISTORY

Allergies
 Feeding Problems
 Operations
 Hospitalizations

BEHAVIOR / DEVELOPMENTAL HISTORY

Developmental Milestones Normal? Y N
 Held Up Head
 Rolled Over
 Sat Alone
 Stood Alone
 Walking
 Talking
 (If YES to the following, please explain below.)
 Behavior Problems
 Learning Problems
 Problems Relating to Peers
 School Progress
 Sleep Problems

REMARKS _____

FAMILY / SOCIAL HISTORY

Parent's Age Education Occupation
 Parent's Age Education Occupation
 Marital Status Child Lives Withl
 Adoption
 Number of People Living at Home
 Smokers in the House?
 Alcohol / Drugs / Guns?
 Pets
 Siblings Ages
 Grandparents Living with Family? (Mom's? Dad's? Both?)

FAMILY RELEVANT ILLNESS

Please circle all that apply -- for immediate family members, including grandparents -- and note who has/had the illness (and the specific type, if applicable.)

Alcoholism
 Arthritis
 Asthma
 Birth Defects
 Blood Disease
 Bone Disorders
 Cancer
 Coronary Artery Disease
 Drug Dependency
 Ear Disorders
 Glandular Disease (Diabetes, Thyroid)
 High Blood Pressure
 High Cholesterol
 Joint Disorders
 Kidney Disease
 Lung Disease
 Mental Retardation
 Muscle Disease
 Neurological Disease
 Obesity
 Psychiatric Disorders
 Sickle Cell
 Sudden Death (<55 Yrs Old)
 Urinary Disease
 Venereal Disease