Today's Date_____.

Child's Name_____DOB_____Sex_____

Family Background

Mother's Name_____DOB_____Occupation_____

Medical problems_____

Father's Name_____DOB_____Occupation_____

Medical problems_____

Names of other children	Age	Sex	Medical problems
1.			
2.			
3.			
4.			
5.			
6.			

Child's Medical History

Does or did your child have any delays in development? Were there any treatments for this?

Please Note the type of delay and treatments for it below.

Does your child have any allergies to medications or food, seasonal allergies, asthma, or eczema? Please describe below.

Has your child ever been hospitalized? If yes, please give details below of each admission as best you can (why they were admitted, how old they were, which hospital, how long they stayed).

Has your child had any surgery" if yes, please give details below (what surgery, how old they were, which hospital).

Has your child had any broken bones, or concussions? If yes, please give details below.

Does your child take any medications on a regular basis? If yes, please give details below.

Does your child seem to see and hear well?

Mother's Pregnancy History

Do you have a history of premature births? How many and how early was the delivery?

Do you have a history of difficulties with becoming pregnant?

During the pregnancy with this child, did you have any significant illness, medical problems, accidents, surgery or hospital stays? If so, please describe below.

Was your delivery vaginal or C-section?

Did the baby cry and breathe normally after birth?

Did the baby require any resuscitation, breathing support, or oxygen after birth?

Were there any feeding difficulties and/or jaundice after birth?

How many days did the baby stay in the hospital after being born?

Patient name: _____ DOB: _____

Family History

Condition: Relation to patient (mother, father, sibling, etc):

- ☐ ADHD _____
- ☐ Allergies or hay fever _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Arthritis _____
- ☐ Bleeding problems _____
- ☐ Birth defects/genetic defects _____
  -What kind of defect? _____
- ☐ Cancer _____
  -What kind of cancer? _____
- ☐ Blood clotting problems _____
- ☐ Depression _____
- ☐ Diabetes- type 1 _____
- ☐ Diabetes- type 2 _____
- ☐ Down syndrome _____
- ☐ Epilepsy/seizures _____
- ☐ Food allergies _____
  -What kind of food? _____
- ☐ Hearing loss _____
- ☐ Heart attack _____
- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ Hyperthyroidism ("high thyroid") _____
- ☐ Hypothyroidism ("low thyroid") _____
- ☐ Infertility _____
- ☐ Irregular heartbeat _____
- ☐ Intellectual disability/developmental delay: _____
- ☐ Kidney trouble (renal disease) _____
- ☐ Mood disorder or bipolar _____
- ☐ Neurofibromatosis _____
- ☐ Obesity _____
- ☐ Metabolic disease at birth _____
  -What kind of disease? _____
- ☐ Schizophrenia _____
- ☐ Smoking _____
- ☐ Stillbirth _____
- ☐ SIDS (sudden infant death) _____
- ☐ Stroke _____
- ☐ Vision loss _____
- ☐ Violence/domestic abuse _____
- ☐ Alcohol abuse _____
- ☐ Drug abuse _____