

Date Form Completed: _____ Child's Name: _____

Age: _____ Date of Birth: _____

Birth History

Birthplace: _____ Birth weight: _____ Birth length: _____ inches

Was pregnancy normal? Yes ___ No ___ If no, explain: _____

Was baby full-term? Yes ___ No ___ If no, at what gestational week was baby delivered? _____

Was delivery normal? Yes ___ No ___ If no, describe any complications: _____

Were there any nursery problems? Yes ___ No ___ If yes, explain: _____

Ethnic background of biological parents: (circle) White Hispanic Black American Indian Asian Filipino Pacific Islander

Growth & Development

Do you use any special diets for your child? Yes ___ No ___ If yes, describe: _____

Is your child taking fluoride? Yes ___ No ___ Does your child drink bottled water or tap water? _____

Ages when your child first:

Rolled _____ Sat up unassisted _____ Crawled _____ Used first word: _____ Walked: _____

Received first teeth: _____ Put words together: _____ Discontinued bottle: _____ Became toilet-trained: _____

School History

Current year in school: _____ Grades average: _____ School name: _____

Attends special school or classes? Yes ___ No ___ If yes, describe: _____

Past Medical History

Does your child currently take any medications? Yes ___ No ___

If yes, please list: _____

Known allergies or allergic reactions:

(e.g., drugs, asthma, hives, hay fever) _____

Hospitalizations: when, where, why?

Date	Hospital	Reason

Serious injuries:

Date	Where treated?	Cause

Any history or problem with: (circle all that apply)

Seizures	Yes No	Rebellious behavior	Yes No
Diabetes	Yes No	Difficulty concentrating	Yes No
Asthma	Yes No	Cries easily	Yes No
Hay Fever	Yes No	Fearful	Yes No
Heart disease	Yes No	School Problems	Yes No
Ulcers	Yes No	Other: _____	
Cancer	Yes No	_____	
Bed-wetting	Yes No		
Speech/Hearing	Yes No		
Eczema	Yes No		

Contagious diseases (at what age) ?

Measles Yes ___ No ___ Scarlet Fever Yes ___ No ___

Chickenpox Yes ___ No ___ Any other: _____

Mumps Yes ___ No ___

General Survey

Has your child had any unusual problems with the following:

Eyes, Ears, Nose, Throat	Yes ___ No ___	If yes, explain: _____
Heart, Lungs	Yes ___ No ___	If yes, explain: _____
Stomach, Intestines	Yes ___ No ___	If yes, explain: _____
Kidney, Bladder	Yes ___ No ___	If yes, explain: _____
Blood	Yes ___ No ___	If yes, explain: _____
Immune System	Yes ___ No ___	If yes, explain: _____
Bones, Muscles	Yes ___ No ___	If yes, explain: _____
Tooth decay	Yes ___ No ___	If yes, explain: _____

Family History

Child's father: Living? ___ Age: ___ Health: _____ If deceased, cause of death? _____
 Child's mother: Living? ___ Age: ___ Health: _____ If deceased, cause of death? _____

Siblings: How many? _____

Do the child's parents live together? Yes ___ No ___ Are there smokers in the child's home? Yes ___ No ___

Family History of:

Allergies	Yes ___ No ___	Who: _____
Cancer	Yes ___ No ___	Who: _____
Heart disease	Yes ___ No ___	Who: _____
Asthma	Yes ___ No ___	Who: _____
Diabetes	Yes ___ No ___	Who: _____
Tuberculosis	Yes ___ No ___	Who: _____
Other	Yes ___ No ___	Who: _____

How long has your family lived in this area? _____

Where did you live prior to this area? _____

Any additional information you believe we should know about your child? _____

Your child's last/previous physician's name: _____

To the best of my knowledge, the information provided herein is true and accurate.

 Name (print)

 Signature