



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: _____ Grade point 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
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_____	_____	_____
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_____	_____	_____
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Serious injuries:

Date	Where treated?	Cause
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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/gender? _____

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

Where did you live prior to this area? _____

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