

Infancy, Childhood, Adolescence History
(Please Print)

Date: _____

CHILD'S INFORMATION

Child's Name _____ Previous Doctor _____
Date of Birth _____ M F Child's School Name _____

CHILD'S BIRTH HISTORY

- During your pregnancy with this child, did you:** (Circle One)
- | | | | |
|--|--------|--|--------------|
| 1. Have high blood pressure? | Yes No | 10. Drink alcohol? | Yes No |
| 2. Have diabetes or sugar in your urine? | Yes No | 11. How long was your pregnancy? | _____ Months |
| 3. Have albumin or protein in your urine? | Yes No | 12. How early did you start seeing the doctor? | _____ Month |
| 4. Have a urinary infection? | Yes No | 13. Have this child early (premature)? | Yes No |
| 5. Take any medicines? | Yes No | 14. Have more than one baby delivered? | Yes No |
| 6. Smoke cigarettes? | Yes No | 15. Have a difficult labor/delivery? | Yes No |
| 7. Take drugs? | Yes No | Was it a breech (bottom first) delivery? | Yes No |
| 8. Get treatment for a STD? | Yes No | Was it a cesarean delivery? | Yes No |
| 9. Tested positive for HIV or Hepatitis C? | Yes No | | |

CHILD'S PAST/PRESENT MEDICAL/ NUTRITIONAL HISTORY

- | | | | |
|--|--------|---|--------|
| 1. Did your baby breathe/cry immediately at birth? | Yes No | 8. During baby's FIRST year did you formula feed? | Yes No |
| 2. Was the baby jaundice at birth? | Yes No | How long? _____ | |
| 3. Receive blood? | Yes No | 9. If feeding problems, explain _____ | |
| 4. At birth, did the baby appear normal? | Yes No | 10. Weaning from breast completed at _____ | |
| 5. Was the Newborn Screening Blood test done? | Yes No | 11. Whole milk started at _____ | |
| 6. Was the hearing screen done? | Yes No | Problems/Allergies? _____ | |
| Did the baby "pass"? | Yes No | Solid food started at _____ | |
| 7. During baby's FIRST year, did you breast feed? | Yes No | Problems/Allergies? _____ | |
| How long? _____ | | | |

IMPORTANT MEDICAL INFORMATION

| Illness/Accident/Surgery | Complications/Severity | Allergic reactions to: Drugs, Food? | Age of Child |
|--------------------------|------------------------|-------------------------------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

IMMUNIZATION INFORMATION

1. Do you have your child's immunization records? Yes No 2. Did you bring the records? Yes No

SOCIAL/DEVELOPMENTAL HISTORY

- | | |
|--|---|
| 1. Child has how many sisters _____ brothers _____? | 1. Child sat up at what age? _____ |
| 2. Child is _____ in the family? (oldest, youngest, middle) | 2. Child crawled at what age? _____ |
| 3. Who does the Child live with? _____ (Father, mother, parents, etc.) | 3. Child walked at what age? _____ |
| 4. Does child go to day care, baby sitter or preschool on a regular basis? Circle One: Yes No | 4. Child started talking at what age? _____ |
| 5. Domestic violence issues? Yes No | |

FAMILY HISTORY

Has any blood relative of your child ever had or been treated for:

- | | | | |
|----------------------|----------------------|----------------------------------|----------------------|
| Allergies | Circle One YES NO | Heart trouble | Circle One YES NO |
| Blood disease | YES NO | Diabetes (Sugar in urine) | YES NO |
| Cancer | YES NO | Tuberculosis (T.B.) | YES NO |
| Lung disease/ Asthma | YES NO | Mental illness | YES NO |
| | | Anybody smoking in the household | YES NO |

CONCERNS/PROBLEMS

Does your baby/child have any on-going problem that concerns you? If yes, put an X in the box that applies

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Eats too little | <input type="checkbox"/> Eats too much | <input type="checkbox"/> Speaks unclearly | <input type="checkbox"/> Always has a runny nose and /or cough |
| <input type="checkbox"/> Cries a lot | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Doesn't always respond to noise or spoken word | <input type="checkbox"/> Sees poorly |
| <input type="checkbox"/> Won't sleep | <input type="checkbox"/> Frequently constipated | <input type="checkbox"/> Seems small for age | <input type="checkbox"/> Wets bed |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Overweight | <input type="checkbox"/> Are there any other problems? Please write them down |

PARENT OR GUARDIAN SIGNATURE: _____