

## MEDICAL HISTORY

### FAMILY HISTORY

Health Problems (note: F - Father, M - Mother, S - Sibling, GF - Grandfather, GM - Grandmother, A - Aunt, U - Uncle, C - Cousin)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Heart Attack or Stroke at<br>age less than 60 _____ | <input type="checkbox"/> Asthma _____       | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Cancer (list type) _____ |
| <input type="checkbox"/> High Blood Pressure _____                           | <input type="checkbox"/> Sudden Death _____ | <input type="checkbox"/> Allergies _____    | _____   |
| <input type="checkbox"/> ADHD _____  | <input type="checkbox"/> Diabetes _____     | <input type="checkbox"/> Anemia _____       | _____   |
| <input type="checkbox"/> Seizures _____                                      | <input type="checkbox"/> Other _____        |   |   |

### CHILD'S HEALTH HISTORY

**Birth:** Weight: \_\_\_\_\_ Type of Delivery: \_\_\_\_\_

Newborn Problems: \_\_\_\_\_

Hospitalization/Surgery: \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Check appropriate items child has had in past:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Urinary Infection |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Seizures                | <input type="checkbox"/> Allergies         |
| <input type="checkbox"/> ADHD          | <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Chicken Pox       |
|  |  | <input type="checkbox"/> Other             |

Has your child had any problems in his/her development? \_\_\_\_\_

### SOCIAL HISTORY

Household Members: \_\_\_\_\_

Any smokers in the home? (N/Y)    Any Pets? \_\_\_\_\_

Childcare:  Attends school/preschool     Attends daycare (if yes, circle one: full time or part time)     Stays home

Any other important information about your child: \_\_\_\_\_