INFANCY, CHILDHOOD, ADOLESCENCE HISTORY

DATE: ______________

I. CHILD'S INFORMATION

Child's Name: ______________________________
LAST FIRST

Previously Seen / Treated By: ______________________________
Name of Doctor

Date of Birth: ______________________________

Mother's Name: ______________________________
LAST FIRST

Social Security No.: ______________________________

Mother's Cell Phone No.: ______________________________

Child Lives With: ______________________________
Fill in Mother/Father, Parents, Etc.

Father's Name: ______________________________
LAST FIRST

Address: ______________________________
Street

____
City State Zip

Father's Cell Phone No.:______________________________

Home Telephone No. ______________________________

Father's Address ______________________________
Street City State Zip

II. CHILD'S BIRTH HISTORY

Place of Child's Birth: ______________________

During your pregnancy with this child did you:

1. Have high blood pressure? ☐YES ☐ NO
2. Have diabetes or sugar in your urine? ☐YES ☐ NO
4. Have German (3 day) Measles? ☐YES ☐ NO
5. Take any medicines? ☐YES ☐ NO
6. Smoke cigarettes? ☐YES ☐ NO
7. Get treatment for gonorrhea or syphilis? ☐YES ☐ NO
8. Test positive for vaginal Group B Strep? ☐YES ☐ NO
9. Drink alcohol? ☐YES ☐ NO
10. Use other drugs? ☐YES ☐ NO
11. Have this child early (premature)? ☐YES ☐ NO
12. Have more than one baby delivered? ☐YES ☐ NO
13. Have a difficult labor and / or delivery? ☐YES ☐ NO
14. Was it breech (bottom first) delivery? ☐YES ☐ NO
15. Was it a Cesarean delivery? ☐YES ☐ NO
16. What was your due date? ___________________
17. How early did you start seeing the doctor? ______ Months
18. What is mother's blood type? ______
19. What is baby's blood type? ______

III. CHILD'S PAST/PRESENT MEDICAL / NUTRITIONAL HISTORY

1. Baby's birth weight ___lbs ___oz
2. Did your baby breathe / cry immediately at birth? ☐YES ☐NO
3. Was the baby jaundiced at birth ☐YES ☐NO
4. Did the baby have an RH problem? ☐YES ☐NO
   Receive blood? ☐YES ☐NO
5. At birth, did the baby appear normal? ☐YES ☐NO
6. Was PKU testing done at birth? ☐YES ☐NO
7. During baby's FIRST year, did you breast feed? ☐YES ☐NO
8. During baby's FIRST year, did you formula feed? ☐YES ☐NO
   How long? _______________________________
9. If feeding problem, explain: __________________
   ____
10. Weaning from breast completed at: ___________ Age
11. Solid food started at: ______________________ Age

    Problems/Allergies? ________________________

IV. IMPORTANT MEDICAL INFORMATION

ILLNESS / HOSPITALIZATION ACCIDENT / SURGERY	COMPLICATION / SEVERITY	ALLERGIC REACTIONS TO: DRUGS, FOOD, ETC?	AGE OF CHILD
1.			
2.			
3.			
4.			
5			
6.			

Turn Over To Complete

Child's Name: ____
LAST FIRST

V. SOCIAL / DELVELOPMENTAL HISTORY

1. Mother's age? _______ Father's age? _______
2. Child has how many sisters? _______ Brothers? _______
3. Child is _________________________________ in family?
   Oldest, Youngest, Middle
4. Other children's ages _____ / _____ / _____ / _____ / _____ / _____
5. Who spends the most time caring for child? ____________________
6. Does child go to day care, baby-sitter or preschool on a regular basis? ☐YES ☐ NO
7. Are there any pets in the home? ☐YES ☐ NO Number_______ Type____
8. Child sat up at: ________________ Age
9. Child crawled at: ______________Age
10. Child walked at: ______________ Age
11. Child started talking at: _________ Age
12. Any Smokers in the home? ☐YES ☐ NO

VI. FAMILY HISTORY

Check box that applies for any relative who has been treated for the following conditions:

Condition	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Sibling
Allergies							
Cancer							
Diabetes (sugar in urine)							
Gastrointestinal Disease							
Heart Disease (including High Blood Pressure, High Cholesterol)							
Kidney Disease							
Lung Disease (including Asthma)							
Mental Illness (including alcohol / substance abuse)							
Tuberculosis (TB)							
Vision or Hearing Impaired							

VII. CONCERNS / PROBLEMS

Does your baby / child have any on-going problem(s) that concern you? Please check all that apply.

☐ Eats too little
☐ Eats too much
☐ Speaks unclearly
☐ Cries a lot
☐ Has frequent temper tantrums
☐ Wets bed
☐ Difficulty sleeping
☐ Frequently constipated
☐ Seems small for age
☐ School problems
☐ Behavior problems
☐ Sees poorly
☐ Doesn't always respond to noise or spoken words
☐ Always has runny nose and / or cough
☐ Are there any other problems? Please list.

____

____

Signature___________________________**Reviewed by**_________________________**Date**______________