Children's Medical History (for parent/s to fill out):

Child's name_____Date of birth_____Today's date_____

ALLERGIES to drugs/ dye/ tape/ bees, etc: **REACTION** (what happened when child was exposed to it?):

_____ _____

_____ _____

_____ _____

Did the child or one of their close blood relatives ever have these? Who? At what age?

☐ Developmental delay or malformation_____

☐ Heart condition during childhood_____

☐ Heart attack or sudden death under age 65_____

☐ High cholesterol or triglycerides_____

☐ Bleeding problem or blood clots_____

☐ Asthma_____

☐ Thyroid problem_____

☐ Diabetes_____

☐ Cancer (what kind?)_____

☐ Depression/ suicide_____

☐ Alcohol or drug problems_____

☐ Other health problems that might run in your family:_____

Has child had: ☐ Chickenpox ☐ Pertussis ☐ Mumps ☐ Measles ☐ Other:_____

Important illnesses or injuries, dates, and how treated:

Please list all medications, vitamins, homeopathics, herbs, and natural supplements child takes.

Name:	Dosage (mg, droppers, etc.):	How/how often:	What's it for?

Last dentist visit:_____Last eye exam:_____Last hearing test:_____

Birth History:

Mom's age when child was born:_____How many weeks was mom pregnant?_____

Siblings at home and ages when child was born:_____

Birth weight: _____ ☐ "small for gestational age" ☐ "large for gestational age"/ macrosomia

Method of birth: ☐ normal (vaginal) ☐ vacuum/ forceps ☐ planned cesarean ☐ emergency cesarean

Place of birth: ☐ Home ☐ Freestanding birth center ☐ Hospital ☐ Other_____

(☐ No medical problems or procedures during pregnancy, birth, or while newborn)

Problems during pregnancy:_____

☐ High blood sugar, treatment:_____

☐ High blood pressure, treatment:_____

☐ Mom GBS (strep) positive, got antibiotics during labor ☐ GBS positive, other treatment:_____

☐ Mom Rh negative, got Rhogam shot after birth ☐ Rh negative, other treatment:_____

Problems during labor or delivery:_____

After birth: ☐ Jaundice ☐ Needed bili-lights or bili-blanket ☐ Needed blood transfusions due to jaundice

☐ Circumcised ☐ Other cosmetic surgery:_____

Nursery or intensive care needed, why and how many days:_____

_____

Infant feeding:

☐ Breastfed only (how long?)_____ ☐ Mother's milk from bottle (how long?) _____

☐ Formula fed (what kind, how long?)_____

☐ Breastmilk + formula (how long?)_____Age started solids:_____

Feeding problems/concerns:_____

Current diet:

How many meals does child eat in 24 hrs?_____How many snacks does child have in 24 hrs?_____

Any special diet at this time:_____

Does child:

☐ Eat breakfast? How often_____ ☐ Eat at a restaurant? How often_____

☐ Eat meat/poultry? How often_____ ☐ Drink fruit juice? How often_____

☐ Eat fish? How often_____ ☐ Drink soda pop? How many a day_____

☐ Eat/drink dairy? How often_____ ☐ Eat chips/salty snack? How often_____

☐ Eat fast food? How often_____ ☐ Eat sweet treat/dessert? How often_____

Favorite foods:_____

Foods child/family avoids, and why:_____

☐ Receiving vaccinations on the usual schedule ☐ No shots; reason:_____

☐ Selected vaccines only:_____

☐ We'd like more information about childhood vaccination:_____

Development: At what ages did child:

sit up alone_____ say words_____ learn to read_____

walk alone_____ toilet train (daytime)_____ 1st menstrual period_____

Activities and safety:

Where does child live or stay, when, and with whom?_____

_____

Pets at home:_____

Other animals at home:_____

Is child in day care or school?_____Where:_____

How many hours a day_____ How many days a week_____ Concerns?_____

After-school activities:_____

Hours TV per day_____ Hours computer per day_____

Spiritual practice or church activities_____

How many times a week does child:

Do artwork at home_____ Play outside (at home)_____

Read or have book read to them_____ Do household chores_____

Has child ever had a concussion or loss of consciousness? How many times:_____

Does child use ☐ car seat ☐ booster seat ☐ seat belt, every time ☐ seat belt, when reminded

Does child wear ☐ bike/skate helmet, every time ☐ bike/skate helmet, when reminded ☐ no biking/ skating

☐ Long-term or repeated health problems:_____

☐ Long-term or repeated behavior/emotional problems:_____

☐ Concern about learning or achievement:_____

☐ Concern about growth or development:_____

☐ Concern about child's safety or well-being, including sexual:_____

_____

If child misbehaves, how do you handle it?_____

How do others handle it, who care for your child?_____

☐ Any guns in the home/s? How are they stored:_____

☐ Any alcohol kept at home? How is it stored:_____

☐ Smokers at home? Who and where:_____

☐ Prescription medication or medical marijuana in the home/s? How is it stored:_____

_____

Other comments or concerns:

That's all! Thank you for filling out this CONFIDENTIAL medical history.