Name_____ DOB_____ Chart_____

Medical History

CHILD'S BIRTH HISTORY (IF KNOWN):

Type of delivery (check one) Vaginal___ C-Section___ Premature birth? Yes___ No___

How many weeks at delivery?_____ Birth weight (pounds)_____

Did the mother have any complications during pregnancy? Yes___ No___

If yes, explain:_____

Did the mother have any complications during or around the birth?

If yes, explain:_____

CHILD'S PAST MEDICAL HISTORY:

Any significant past medical history? Yes___ No___

Previous hospitalizations? Yes___ No___

If yes, explain:_____

ADD/ADHD	Yes___	No___	Concussion	Yes___	No___	Psychiatric disorders	Yes___	No___
Allergies	Yes___	No___	Diabetes	Yes___	No___	Recurrent colds	Yes___	No___
Anemia	Yes___	No___	Eczema/Rash	Yes___	No___	Sinus infections	Yes___	No___
Asthma	Yes___	No___	Fracture	Yes___	No___	Seizure disorder	Yes___	No___
Blood disorders	Yes___	No___	Acid Reflux	Yes___	No___	Thyroid disorder	Yes___	No___
Bronchiolitis	Yes___	No___	Headache	Yes___	No___	Ear infections	Yes___	No___
Chickenpox	Yes___	No___	Migraine	Yes___	No___	Trauma	Yes___	No___
Chronic illness	Yes___	No___	Pneumonia	Yes___	No___	Developmental Delays	Yes___	No___
Heart defect	Yes___	No___	Tonsillitis	Yes___	No___			

CHILD'S SURGICAL HISTORY:

Appendix removed	Yes___	No___	Year?_____	Hernia repair	Yes___	No___	Year?_____	
Tonsils removed	Yes___	No___	Year?_____	Ear tubes	Yes___	No___	Year?_____	
Significant surgeries	Yes___	No___						

If yes, explain:_____

CHILD'S SOCIAL HISTORY:

Living with parents	Yes___	No___	Tobacco use	Yes___	No___	Enrolled in daycare	Yes___	No___
Living in foster home	Yes___	No___	Alcohol use	Yes___	No___	Exposure to cigarettes or vaping		
Pets in the home	Yes___	No___	Drug use	Yes___	No___	(at home or in car)	Yes___	No___

FAMILY HISTORY:

Asthma	Yes___	No___	Who?_____	Childhood Hearing Loss	Yes___	No___	Who?_____	
Alcoholism	Yes___	No___	Who?_____	Developmental Disability	Yes___	No___	Who?_____	
Birth defects	Yes___	No___	Who?_____	High blood pressure	Yes___	No___	Who?_____	
Cancer	Yes___	No___	Who?_____	Kidney disease	Yes___	No___	Who?_____	
Diabetes	Yes___	No___	Who?_____	Crohn's disease	Yes___	No___	Who?_____	
Drug use	Yes___	No___	Who?_____	Mental illness	Yes___	No___	Who?_____	
Epilepsy	Yes___	No___	Who?_____	Thyroid disease	Yes___	No___	Who?_____	
Migraine	Yes___	No___	Who?_____	High cholesterol	Yes___	No___	Who?_____	
Obesity	Yes___	No___	Who?_____	Systemic Lupus	Yes___	No___	Who?_____	
Stroke	Yes___	No___	Who?_____	GI disease	Yes___	No___	Who?_____	
Tuberculosis	Yes___	No___	Who?_____	Rheumatoid Arthritis	Yes___	No___	Who?_____	
Heart Disease	Yes___	No___	Who?_____	Other_____				