NAME____**M**____**F**____ **DOB:**_________________________

PAST MEDICAL HISTORY

Allergic Reaction:

Medicine _________________________

Food ____________________________

Insect____________________________

Other ____________________________

Are immunizations up-to-date? ___________
Is your child taking any regular medication? ________

Hospitalizations/Surgeries:

1. Date/Age: _______________________________________

   Hosp: ____

   Dx/Tx: ____

2. Date/Age: ______________________________________

   Hosp: ____

   Dx/Tx: ____

Has Development been normal? ____

Any physical or mental handicap? ____

School problems? ____

BIRTH HISTORY

Gestational Age __________

Delivery Weight __________

Type of Delivery _________

PROBLEMS/COMPLICATIONS:

NEONATAL

Infection: ____________________

Jaundice: __________________

Other: ____________________

FEEDING

Breast ____, Formula ____

Water supply:
City ____

Well ____

Bottled____

FAMILY HISTORY

Mother ___________________ Age _____

Father ____________________Age_____

Siblings of the Patient:
1.________________________Age _____

2.________________________Age _____

3. ________________________Age _____

4. ________________________Age_____

Please check any of the following which occur in the family.

Heart Attack/Stroke __________
Asthma/Eczema/Hay Fever ____
Bleeding Disorder ___________
Congenital Heart Disease ______
Cancer ___________________
Anemia ___________________
Cystic Fibrosis ______________
Mental Retardation ___________
Migraine __________________
Hypertension _______________
Alcoholism/Depression _______________________________

Muscular Dystrophy _____
Diabetes ______________
Seizures ______________
Arthritis _______________
Tuberculosis ___________
Sickle Cell _____________
SIDS _________________
GI Disorder ____________
Deafness ______________
AIDS _________________

Other ____