CHILD'S NAME: _____ **DATE OF BIRTH**: _____

PATIENT and FAMILY HISTORY

1. What medical problems does the child have? What medical problems do people in the child's family have?

Medical Problems:	**Who has the medical problem (please circle):**				
Birth Defects	Child	Mother	Father	Brother/Sister	Grandparent
Obesity (Overweight)	Child	Mother	Father	Brother/Sister	Grandparent
Congenital Hearing Loss / Hearing Problems	Child	Mother	Father	Brother/Sister	Grandparent
Mental Retardation	Child	Mother	Father	Brother/Sister	Grandparent
Migraine Headaches	Child	Mother	Father	Brother/Sister	Grandparent
Allergies	Child	Mother	Father	Brother/Sister	Grandparent
Asthma (Trouble Breathing)	Child	Mother	Father	Brother/Sister	Grandparent
Heart Disease or Heart Problems (Murmur, Hole in Heart)	Child	Mother	Father	Brother/Sister	Grandparent
Sudden Death of Infant / Baby	Child	Mother	Father	Brother/Sister	Grandparent
Arthritis (Pain in the Joints)	Child	Mother	Father	Brother/Sister	Grandparent
AIDS	Child	Mother	Father	Brother/Sister	Grandparent
Cancer	Child	Mother	Father	Brother/Sister	Grandparent
Thyroid Problems	Child	Mother	Father	Brother/Sister	Grandparent
Diabetes (Sugar)	Child	Mother	Father	Brother/Sister	Grandparent
Muscular Dystrophy	Child	Mother	Father	Brother/Sister	Grandparent
Cystic Fibrosis	Child	Mother	Father	Brother/Sister	Grandparent
Anemia (Low Iron in the Blood)	Child	Mother	Father	Brother/Sister	Grandparent
Sickle Cell Disease	Child	Mother	Father	Brother/Sister	Grandparent
Epilepsy (Seizures)	Child	Mother	Father	Brother/Sister	Grandparent
Chron's / Colitis (stomach or bowel problems)	Child	Mother	Father	Brother/Sister	Grandparent
ADD / ADHD (Have trouble paying attention or sitting still)	Child	Mother	Father	Brother/Sister	Grandparent
Skin Problems (Acne, Flaking, Rashes)	Child	Mother	Father	Brother/Sister	Grandparent
Cerebral Palsey	Child	Mother	Father	Brother/Sister	Grandparent
Other (Please List):	Child	Mother	Father	Brother/Sister	Grandparent

2. Check all the people that the child lives with:

□ Mother □ Father □ Brothers and Sisters (how many? ____)

□ Other family members (list: _____)

□ Friends or other people (list: _____)

□ Animals: □ Dogs □ Cats □ Other animals (list: _____)

3. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No (Go to Question #5)

☐ Yes (Explain why and when below):

My child was in the hospital because:	**When:**
Example: *Bike Accident*	*5 Years Old*

4. Is your child taking any **prescription medicines**?

☐ Yes – Please list the child's medicines below or ☐ I brought my child's medicines.

☐ No, my child does not take any prescription medicines. (Go to Question #6)

Name of Medicine	**Amount / size of pill**	**How many pills or doses does your child take at:**
Example: *Dexadrine*	*10 mg*	*1* morning ___noon ____dinner ___bedtime
		__ morning ___noon ____dinner ___bedtime
		__ morning ___noon ____dinner ___bedtime

5. What **over-the-counter** medicines does your child take?

☐ Vitamins

☐ Herbal Medicines (Please list: _____)

☐ Other (Please list: _____)

☐ None – my child does not take any over-the-counter medicines.

6. Does your child have any **allergic reactions (bad effects)** from any of the following? Check all that apply:

☐ Outdoor or Indoor allergies (for example: grass, pollen, cats, bee stings……)

☐ Food Allergies (for example: milk, peanuts, wheat….). Please list below.

☐ Medicines or shots (immunizations). Please list below.

☐ No, my child has no allergies that I am aware of. (Go to Question #8)

Medicine or food that child is allergic to:	**What happens when the child eats that food or takes that medicine?**
Example: *Penicillin*	*Big red spots on skin (Hives)*

7. Does the child go to **school or daycare**?

☐ No

☐ Yes (Name of school or daycare facility: _____)

8. Does the child live with anyone who smokes? ☐ Yes ☐ No

9. Does the child smoke? ☐ Yes ☐ No

10. What type of water is used in the child's house? ☐ City Water ☐ Well Water

ABOUT MOM WHEN PREGNANT

The next questions are about the mother of the child during pregnancy and birth. If you do not know about the pregnancy of the mother, check here ☐ .

11. Did the mother use any of the following **during pregnancy**?

- ☐ Cigarettes
- ☐ Alcohol
- ☐ Illegal drugs (which ones? _____)
- ☐ Prescription drugs (which ones? _____)
- ☐ None of these were used by the mother during pregnancy

12. Did the mother have any of these **conditions or problems during pregnancy**?

- ☐ Preeclampsia (High Blood Pressure)
- ☐ Diabetes (Sugar)
- ☐ Emotional Stress
- ☐ Injury or Serious Illness
- ☐ Unexpected Bleeding or Spotting
- ☐ Other _____

13. Was the birth:

- ☐ On the due date
- ☐ Before the due date (by how much _____)
- ☐ After the due date (by how much _____)

14. Was the baby born by C-Section (surgical cut in the tummy)? ☐ Yes ☐ No

15. Were there any **problems during the birth**? ☐ Yes ☐ No

If yes, please explain: _____