

Medical History

Date:

Child's Name		Birthdate	Age	Sex:
Home Address			Phone	
County	City	State	Zip Code	

Your relationship to child (Please circle)

Mother

Father

Grandparent

Foster Parent

Other

Father:	Occupation:
Ethnic Background (optional)	Religion (optional)

Health/Birthdate

Mother:	Occupation:
Ethnic Background (optional)	Religion (optional)

Health/Birthdate:

Who referred you here for evaluation?

What is it about your child that concerns you?

When was it first noticed?

What have you been told about your concerns?

What things do you presently not understand about your child?

How do you think that we might be able to help you?

How do you feel your child can best be helped?

Pregnancy

Questions in this and the following section refer to the pregnancy of the child coming for the appointment

Did you have any problems getting pregnant?

Was this a planned pregnancy? Feelings about being pregnant?

During which month did you start prenatal care? Where?

Weight before pregnancy? Weight gain?

Any weight loss in any part of pregnancy? If so, when?

Medicines taken and when? (include all medication such as vitamins, birth control pills, etc, including aspirin if taken frequently)

How much did you smoke during the pregnancy?

During which months of pregnancy?

Early

Middle

Late

How many cigarettes per day?

How much alcohol did you consume during your pregnancy?

Number of alcoholic drinks per week?

During which months of pregnancy?

Early

Middle

Late

Any other drugs during or prior to this pregnancy?

Describe all illnesses and when during the pregnancy that they occurred?

Early

Middle

Late

Early

Middle

Late

Early

Middle

Late

Did you have any fever during the pregnancy?

Early Middle Late

If so, how high was fever? For how long did it persist?

X-rays during or shortly before pregnancy?	Vaginal bleeding
High blood pressure?	Much morning sickness?
Much swelling?	Hospitalizations?
Operations?	Accidents?
Unusual worries?	Special diet?

When did you first feel the baby move?

How were the baby's movements during pregnancy?

Stronger than expected Weaker than expected About the same as expected

Birth History

Was the baby born on time, early, or late?

Was any stimulation of labor used? What type?

Length of labor in hours? Length of hard labor?

Length of time before delivery that bag of waters broke?

Type of anesthesia or pain relief: (please circle)

Sedative Spinal or caudal Shot for pain relief Gas or Pentothal

Were you awake when the baby was born?

Type of delivery: (please circle)

Natural (vaginal) Cesarean section Breech Forceps

Mother's blood group (ABO)	Mother's Ph factor
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Baby's blood group (ABO)	Baby's Ph factor
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Baby's birth weight	Birth length	Head circumference
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Infant's condition:

Breathed immediately	Cried immediately
Required oxygen	Length of stay in nursery
Seizures or fits	

Problems during the first week (i.e., incubator, yellow skin, feeding difficulties, bleeding tendency, infection, etc.)

Medicines given during the hospital stay

Later hospitalizations and surgeries (including outpatient) of child:

Name of hospital:	Date	Reason
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Health

Breast or bottle-fed	Did child eat well?
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Sleep patterns

Childhood diseases (list age and anything unusual about any of them)

Mumps	3-day (or German) measles	Chicken Pox	7-day (or red) measles
Roseola	Scarlet fever	Whooping cough	Serious illness

Immunizations
(dates or ages received and any unusual reactions:

DPT series	Smallpox	DPT booster
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Measles	Polio (oral)	Mumps
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If your child has had any of the following, please indicate and explain details

Accidents

High fever, unknown cause

Pneumonia

Anemia

Urine infection or disease

Problem in bladder or bowel control

Constipation

Does your child have trouble seeing?

Do your child's eyes turn in or out, or are they ever not straight?

Crossed eyes

Speech problems

Difficulty eating or feeding self

Difficulties in swallowing, chewing or drooling?

Hearing problems

Frequent ear infections

Foot problems (any special shoes, braces, etc)

Skin disease or abnormality

Allergies

Birthmarks

Seizures or convulsions

Unusual fears

Sleeping difficulties or night terrors

Head banging

Rocking

Temper tantrums

Discipline problem

Ingestion of drugs, cleaners, or non-food items

Other illnesses

Development

We would like to have information about some of the developmental milestones of your child. Indicate the age in months when your child first did each of the following. Indicate that the child has not yet done it by writing "no" if you do not remember, write "NR" Please be as specific as possible in pinpointing the age

Head held erect

Sat alone

Rolled over front to back

Crawled

Stood alone

Smiles spontaneously

Walked holding on furniture	Fed self cookie
Walked without holding	Drank from cup
Ran with good control	Played pat-a-cake, peek-a-boo, or bye-bye
Walked up steps	Recognized parents
Rode tricycle	Showed fear with strangers
Said "ma-ma" or "da-da"	Repeated sounds others made
Used spoon without spilling much	Toilet training started
Used words (other than "ma-ma" or "da-da") with meaning	Toilet training finished
Said three single words	Put on clothes
Combined different words	Used sentences
Repeated words others said	Right or left handed

Schools and Day Care

Has child ever been in preschool? When and where?

List all schools (including day care and pre-schools that child has attended)

School Date

School Date

School Date

Has your child ever been held back in school?

Has child ever been in special education? If so, when, where and what kind?

Has child ever been in remedial classes or programs? If so, when, where and what kind?

Has child ever had special tutoring? If so, when, where, and by whom?

Has child ever received speech therapy? If so, when, where, and by whom?

Has child ever received any other type of therapy? If so, please describe

Describe any school problems that you are presently aware of?

Activities

What things does your child like to do?

What things does your child do well?

What things present the greatest difficulty for your child?

Describe play indoors

Describe play outdoors

How does our child play and/or get along with other children?

Give detailed description of an average day

What do you like best about your child?

Dental History

Has your child ever been examined by a dentist?

For what reason

When was you child's last visit to the dentist?

Name and office address of your child's dentist

Family History

Please indicate whether there are any relatives of the child (including parents, grandparents, aunts, uncles, and cousins) who have the same or a similar problem for which you are seeking evaluation. Also indicate for these persons whether there are serious, chronic, or recurrent illnesses or abnormalities such birth defects, miscarriages, diabetes, convulsions or epilepsy (fits), mental or emotional disorders, autism, slow disorders, cancers, leukemia, thyroid disease (goiter), deafness or blindness, speech or language problems, reading or learning disorders.

(Please be as specific as possible, giving relationship to child, age of relative and problem)

Mother

Mother's mother

Mother's father

Mother's brothers and sisters

Mother's maternal grandmother

Mother's maternal grandfather

Mother's paternal grandmother

Mother's paternal grandfather

Mother's aunts and uncles

Mother's cousins

Father

Father's mother

Father's father

Father's brothers and sisters

Father's maternal grandmother

Father's maternal grandfather

Father's paternal grandmother

Father's paternal grandfather

Father's aunts and uncles

Father's cousins

Describe any family tensions

List support sources outside the family (relatives, friends)

Future goals of child's father

Future goals of child's mother

Pregnancy History

Past pregnancies of child's mother: Number of times pregnant

Longest periods of infertility

Live Births	Still births	Miscarriages
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List dates of past pregnancies. Indicate if there was: a miscarriage; threatened miscarriage (bleeding); premature birth; twins; deformity or other difficulty with live-born children; or any other complications. Please list any birth defects, however unimportant you consider them.

Name	Birthdate	Birth weight	Grade in school	Any school or health problems?
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Are the mother and father cousins, or in any other way related?
