INITIAL MEDICAL HISTORY

Today's Date _____

Child's Name _____ Birthdate _____ Sex _____

Address _____ Phone _____

_____ Race _____

FAMILY HISTORY
CHILD'S MEDICAL HISTORY

Chicken Pox		Allergies		Speech problems	
Measles		Asthma		Cardiac problems	
Mumps		Anemia		Heart Murmur	
Rubella		Ear infections		Diabetes	
Pertussis		Dental problems		Seizures	
Rheumatic Fever		Hearing problems		Other	
Pneumonia		Vision problems			

Hospitalizations: _____

Accidents: _____

Medications: _____

HEALTH HABITS

Does the child have & use a car seat/ seat belt? Yes No

SEXUALITY

Sexually active? _____

Dating? _____ OVER →

PRENATAL & BIRTH HISTORY

At what month of your pregnancy did you start prenatal care? _____

Mom's age when baby was born: _____ Number of other pregnancies: _____

Type of delivery: _____ Was baby full term or premature? _____

Did you smoke? Yes No Drink alcohol? Yes No Use drugs? Yes No

Any complications during this pregnancy/labor and delivery? _____

_____

How long were you in the hospital after this birth? _____

How long was the baby in the hospital? _____

DIETARY HABITS

What foods/drinks/snacks has your child had for:

Breakfast Lunch Supper Snacks

_____

_____

Is or was your child breast-fed? _____ Is your child on WIC? _____

Type of formula: _____ Amount: _____ How often? _____

_____Self-fed _____Fingers _____Fork/Spoon_____ Cup_____ Bottle_____

Does your child have any feeding or eating problems? _____

Does your child take vitamins? _____

How is your child's appetite? _____

Do you feel your child is over/under weight? _____

Child's sleep patterns: _____

_____

How do you discipline your child? _____

_____

Does your child have problems at school/home? _____

_____

Describe your child care/babysitting arrangements: _____

_____

What type of family support do you have? _____