FAMILY/SOCIAL HISTORY

Name: ______________________ **Date of birth:** ______________

Has mother had any miscarriages or stillbirths? ________

Has any family member or close relative had?

YES	NO		YES	NO	
___	___	Arthritis	___	___	Asthma
___	___	Cancer	___	___	Chemical Dependency
___	___	Convulsions or Epilepsy	___	___	Nasal Allergies/Hayfever
___	___	Eczema	___	___	Diabetes
___	___	Heart Disease before 55 years	___	___	Hemophilia-Bleeder
___	___	High Blood Pressure	___	___	Kidney Disease
___	___	High Cholesterol	___	___	Migraines
___	___	Mental Disorders	___	___	Educational Development Problems
___	___	Tuberculosis	___	___	Stomach/Colon/Intestinal Problems
___	___	Physical Development Problems	___	___	Other ______________

Names and ages of people in the household: ______________________________

Names and ages of parents, brothers, sisters who do not live in the household: ______________________________

Household member's occupations: ______________________________

Household members in good health?: _____Yes _____No

Types of pets: ______________________________

Child's other regular caretakers: ______________________________

BIRTH HISTORY

Hospital: ______________________ Obstetrician: ______________________

Type of delivery: ______________________ Complications: ______________________

During the pregnancy did mother smoke, use alcohol or other substances, take medicine (beside vitamins) or take hormones?: ______________________________

Birth Weight: ____________ Birth Length: ____________ Discharge weight: ____________

Did your baby have any problems at or immediately after birth?: ______________________________

HEALTH HISTORY

Child's physician: ______________________ City/State: ___________________ Phone: _______________

Date of last physical examination: ____________________________ Results: _____________________________

Is your child under the care of a physician now?: _____Yes _____No

Medications?: ____

____

Has your child been hospitalized?: _____Yes _____No

Date Reason Hospital

____

____

____

Has your child ever had a surgical procedure?: _____Yes _____No

____

____

Does your child have any allergies?: ____

____

Has your child had any history of or difficulty with any of the following?:

YES	NO		YES	NO	
___	___	AIDS/HIV	___	___	Heart Problems
___	___	Anemia	___	___	Hepatitis
___	___	Asthma	___	___	Kidney Disease
___	___	Bed Wetting	___	___	Lead Poisoning
___	___	Birth Defects	___	___	Liver Disease
___	___	Bladder Problems	___	___	Measles
___	___	Bleeding, Excessive	___	___	Mononucleosis
___	___	Cancer	___	___	Mumps
___	___	Cerebral Palsy	___	___	Pneumonia
___	___	Chicken Pox	___	___	Rheumatic Fever
___	___	Constipation/Diarrhea	___	___	Sinus Problems
___	___	Convulsions	___	___	Speech Problems
___	___	Diabetes	___	___	Thyroid Disease
___	___	Drug/Alcohol Abuse	___	___	Tuberculosis
___	___	Ear Infections	___	___	Urinary Disease
___	___	Epilepsy	___	___	Vision Problems
___	___	Fainting	___	___	Worms
___	___	Hearing Problems	___	___	Other ________________
					________________
					________________