CHILD HEALTH HISTORY

Date: _____
Child's name: _____ Date of Birth: _____
Mother's Name: _____ Age: _____
Occupation:_____ e-mail address:_____
Father's Name:_____ Age: _____
Occupation:_____ e-mail address:_____

PREGNANCY AND BIRTH

1. Where was the child born? (Newborns Only) (Hospital/City) _____
2. What doctor saw the child at the hospital? (Newborns Only)_____
3. What was the birth weight? _____ Length? _____
4. How many weeks pregnant were you at delivery? _____
5. Mother's age at birth? _____
6. List any complications at birth:_____
7. Was the child in NICU? Yes No

PAST MEDICAL HISTORY

1.Does your child have any of the following illnesses?

ADHD	Asthma	Cerebral Palsy	Eczema	
Allergies	Autism	Depression	Seizures	None
Anxiety	Bipolar disorder	Developmental Delay	Sickle Cell	

Other:_____

2. Where has your child previously gone for checkups? _____
3. Has your child had allergic reactions to any medications, food, immunizations, or insect bites? Yes No
   If so, please list _____
4. List any hospitalizations, other than birth? _____
5. List any surgeries your child has had? _____
6. List any medications your child takes on a regular basis? _____

ENVIRONMENTAL

1. Primary drinking water: Bottle water Bottle water with fluoride Well Water City tap water
2. Do any people living in the home smoke? Yes No if so, inside or outside? _____
3. List any inside pets:_____ outside pets:_____

FAMILY HISTORY

(Please place an X in the box of any family members who have any of the following diseases listed)

	MOTHER'S SIDE			FATHER'S SIDE			SIBLINGS	
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Brother	Sister
ADHD								
Allergies								
Asthma								
Anxiety								
Autism								
Bipolar disorder								
Cancer								
Depression								
Diabetes								
Heart disease								
High Blood Pressure								
High Cholesterol								
Sickle Cell								
Stroke								
Other								