HISTORY FORM TO BE FILLED OUT BY PARENT

PATIENT'S NAME _____Date_____

A. PREGNANCY AND BIRTH:

1. Did you have an illness during pregnancy? ..... NO - YES
2. Did the baby come on time? ..... NO - YES
3. What was the birth weight _____
4. Did your baby have any trouble starting to breath? ..... NO - YES
5. Did the baby have any trouble while in the hospital? ..... NO - YES

B. FEEDING AND DIGESTION:

1. Was there any severe colic or unusual feeding problems the first 3 months? .. NO - YES
2. Is your child's appetite unusually good? ..... NO - YES
3. Is it good now? ..... NO - YES
4. Do any foods disagree with him/her? ..... NO - YES
5. Does he/she have diarrhea often? ..... NO - YES
6. Has constipation ever been a problem? ..... NO - YES
7. If on vitamins, what kind and how much? _____
8. If still on formula, what one do you use? _____

C. FAMILY HISTORY:

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:

seizures	cancer	inherited or family diseases	diabetes
tuberculosis	asthma	nervous breakdown	allergy

2. Are the child's parents both in good health? ..... NO - YES
3. List the ages, sex and general health of brothers and sisters:

_____

_____

4. Have any of your children died? ..... NO - YES

D. INFECTIONS, ILLNESSES, MISCELLANEOUS PROBLEMS AND DEVELOPMENT:

Has your child:

1. Had as many as three attacks of ear trouble? ..... NO - YES
2. Had more than three colds or throat infections with fever a year? ..... NO - YES
3. Had any trouble with urination? ..... NO - YES
4. Ever had a convulsion? ..... NO - YES
5. Had any trouble with hearing? ..... NO - YES
6. Had any trouble with vision? ..... NO - YES
7. At what age did your child:
   Sit alone _____ Walk alone _____
8. Did your child say any words by age 1 ½ years? ..... NO - YES
9. Does your child have any trouble sleeping? ..... NO - YES
10. Does your child have any dental problems? ..... NO - YES
11. Circle any of the following that your child has had:

"Red" Measles Mumps Chickenpox Broken Bones Whooping Cough Pneumonia
German or "3 day" Measles Serious Accidents Roseola Tonsils & Adenoids Removed

(continue on other side)

Other Operations:_____

Other Diseases:_____

Hospitalizations:_____

E. ALLERGIES:

Has your child ever had:

1. Eczema or hives? …… NO - YES
2. Wheezing or hives? …… NO - YES
3. Allergies or reactions to any medicines or injections? …… NO - YES
4. Does he/she tend to have a stuffy nose or "constant cold"? ……..… NO - YES

F. BEHAVIOR QUESTIONAIRE

1. Are any of your children overly anxious or nervous much of the time? ……..…… NO - YES
2. Are any of your children unhappy, sad or depressed too much? …….. NO - YES
3. Are any of your children too isolated from other children or seem to be afraid of other people? …… NO - YES
4. Is there more turmoil or tension between family members than you think there should be? NO –YES
5. Is there anything that especially concerns you about the behavior of any of your children? NO- YES
   FOR EXAMPLE: Stealing, fighting or being extremely destructive, lying, soiling pants, having frequent nightmares, taking drugs, running away, quitting or being truant from school, and so on.
6. Are any of your children having unusual difficulty with reading, writing, or learning at school? …….. NO - YES
7. Do any of your children frequently wet the bed? …… NO - YES
8. Do any of your children have difficulty talking or have trouble with their speech? ……. NO - YES

F. TESTS:

Has your child had:

1. Hearing problems?…….. NO – YES
2. Vision Tested? …… NO – YES
3. When did your child last see a dentist? _____

G. IMMUNIZATIONS:

Has your child had:

1. A successful smallpox vaccination? …… NO - YES
2. All three DPT's …….. NO - YES
   Date 1st 2nd 3rd Booster
3. All three doses of polio vaccine by mouth:…… NO - YES
   Date 1st 2nd 3rd Booster
4. H.I.B. (Hemophilus Influenza Type B) …… NO – YES
   Date 1st 2nd 3rd Booster
5. Hepatitis B …… NO - YES
   Date 1st 2nd 3rd Booster
6. Measles – Rubella – Mumps vaccine? …… NO - YES
   Date: 5 yr Booster _____ 12 –14 yr Booster _____
7. Skin test for tuberculosis? …… NO - YES
   Date:
8. Chickenpox Vaccine …… NO - YES
   Date: