

Child's Full Name \_\_\_\_\_

Birth Date \_\_\_\_\_

**Birth History**

**Pregnancy, Labor, Delivery & Newborn Period:**

Mother's age at time of child's birth \_\_\_\_\_  
Is this child adopted?  Y  N  
Hospital of delivery \_\_\_\_\_

During pregnancy, did mother use:

- Tobacco
- Alcohol
- Drugs
- Medications
- Tranquilizers

During pregnancy, did mother have:

- Bleeding
- Premature labor
- Illness requiring treatment
- Group Step B result  positive  negative
- Hepatitis B positive
- HIV positive

During delivery, did mother have:

- Vaginal
- C-section
- Breech Position
- Complications
- Antibiotics

During delivery did child have:

- Birth Injury
- Asphyxia (lack of oxygen).

Measurements at birth:

Height \_\_\_\_\_  
Weight \_\_\_\_\_  
Head Circumference \_\_\_\_\_  
APGAR Score \_\_\_\_\_/\_\_\_\_\_

During Newborn period, did child have:

- Infection
- Breathing Problems
- Birth Defect
- Jaundice
- Feeding Problems
- Hearing Evaluations
- Other problems

Infant Nutrition (first 9 months):

- Breast (over one month)
- Formula
- Feeding Problems
- Milk Intolerance
- Poor weight gain/growth

**Past Medical History of child:**

Medication Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Chronic Illnesses:

\_\_\_\_\_  
\_\_\_\_\_

Hospitalization \_\_\_\_\_

Surgery \_\_\_\_\_

Serious Injury \_\_\_\_\_

Serious reaction to Immunization \_\_\_\_\_

Chronic Medications (List)

\_\_\_\_\_  
\_\_\_\_\_

Has your child had any of the following:

- More than three ear infections
- Hearing loss
- Eye or vision problems
- Asthma/recurring bronchitis
- Pneumonia
- Heart murmur or heart problems
- Bladder or Urine infections
- Chronic Bowel Problems
- Eczema or chronic skin condition
- Allergies or hayfever
- Seizures with fever
- Seizures without fever
- Cerebral Palsy
- Developmental Delay
- Significant behavior problems
- Other Problems \_\_\_\_\_

If you have a pool, is it fenced  Y  N

Do you have smoke alarms  Y  N

Does anyone smoke in the home  Y  N

Do you know the hot water temperature  Y  N

Do you use seatbelts and/or car seat  Y  N

Immunizations:

Current/Up to date  Y  N

Please provide a copy of immunization history

Please describe his/her health, attitude and behavior

\_\_\_\_\_  
\_\_\_\_\_