CHILD'S NAME _____ AGE _____ DATE FORM FILLED OUT _____

A. BIRTH HISTORY

1. Birthplace _____
2. Birthdate _____
3. Was pregnancy normal? _____
4. Was delivery normal? _____
5. Was baby full term? _____
6. Birth weight _____
7. Birth length _____
8. Any nursery problems? _____

GROWTH AND DEVELOPMENT

1. Ages when first:
   Sat _____ Crawled _____
   Rolled _____ Walked _____
   First Teeth _____ Toilet Trained _____
2. School History:
   Year in school _____ Nursery _____
   Grades averaged _____
   School name _____
   School problems? _____
   Attends special school or classes? _____
   _____
   Discipline or behavior problem? _____
   _____
   Ever seen by Psychologist, Speech Therapist, or Special Teachers? _____
   _____

PAST MEDICAL HISTORY

1. Any problems with:
   Sleeping? _____ Bedwetting? _____
   Weight/Height? _____ Nail Biting? _____
   Nightmares? _____
2. Diet _____
   Nursed or Bottle Fed? _____
   Any Colic problems? _____
   Use special diets? _____
   Taking Vitamins? _____
   Taking Fluoride? _____
3. Contagious Diseases (What age?) _____
   Measles _____
   Mumps _____
   Rubella (German Measles) _____
   Chickenpox _____
   Scarlet Fever _____
   Any other? _____
4. Immunizations (Shots) – Please give ages and/or dates.
   DPT series _____ Boosters _____
   Polio series _____ Boosters _____
   Smallpox _____ Boosters _____
   Measles _____
   Rubella (German Measles) _____
   Mumps _____
   TB (Tine) Test _____
   Others _____
   _____
5. Medications (Does Your Child Take Any Now?) ___

D. HOSPITALIZATIONS

(When, Where, Why?) _____
_____
_____

E. SURGERY

(When, Where, Why?) _____
_____
_____

F. SERIOUS INJURIES

(When, Where?) _____
_____
_____

G. ALLERGIC REACTIONS

(Drugs, Asthma, Hives, Exzema, Hay Fever) _____
_____
_____

I. FAMILY HISTORY

1. Father: Living? ____ Age now ____ Health _____
2. Mother: Living? ____ Age now ____ Health _____
3. Brothers/Sisters ____ How Many? _____
   Ages _____ Healthy _____
4. Any Family History of:
   Diabetes ____ Allergies ____ Convulsions ____
   Heart Disease ____ TB ____ Cancer ____
   Other? _____

J. HOW LONG HAS YOUR FAMILY LIVED IN THIS AREA? _____

WHERE DID YOU LIVE BEFORE COMING TO THIS AREA? _____
_____

K. GENERAL SURVEY

Has your child had any unusual problems with the following?:

Head _____
Eyes _____
Ears/Nose/Throat _____
Chest/Heart/Lungs _____
Stomach _____
Kidneys _____
Bladder _____
Bones, Muscles, Joints _____
Skin _____
Blood _____

2. When was your child's last blood test? _____
3. When was your child's last urine test? _____

L. ANY SPECIAL COMMENTS ABOUT YOUR CHILD?

_____
_____

M. YOUR LAST DOCTOR WAS _____ ____

FEEDING HISTORY

Breast | Formula | Vitamins

Soft Food | Present Diet | Feeding Habits

Appetite | Likes | Dislikes

Vomiting | Stools | Sensitivity | Hives

IMMUNIZATION AND SKIN TESTING

	Date	Dose
DPT (Diphtheria, Pertussis, Tetanus)		
OPV (Trivalent)		
MEASLES (Live attenuated without ISG)		
TD (Tetanus, Diphtheria) (Adult type)		
TETANUS BOOSTER		

	Date	Dose
MUMPS		
RUBELLA		
OTHER		

	Date	Material	Method	Result
SMALLPOX				
TUBERCULIN				
OTHER				

ILLNESSES

- Pertussis
- Measles
- Rubella
- Mumps
- Chickenpox
- Scarlet Fever
- Diphtheria
- Operations
- T. and A.
- Allergy
- Appendix
- Glands
- Rheumatic Fever
- Otitis
- Colds
- Tonsillitis
- Convulsions
- Constipation
- Diarrhea
- Asthma