

List any illnesses, infections, complications during pregnancy:

Treatments/ Medications During Pregnancy (check):

Tobacco Alcohol Recreational Drugs: List _____

Prescription/ Over-The-Counter Drugs: _____

Supplements/ Others: _____

Did you take Prenatal Classes? Yes / No

Planned or unplanned pregnancy? _____

Helping persons available during pregnancy: _____

Describe your diet during the pregnancy. Indicate cravings also.

How much weight did you gain? _____

Did you experience any of the following (check):

nausea vomiting high blood pressure diabetes

physical or emotional trauma

other _____

Describe your reaction when you first felt the baby move.

Any past miscarriages? Yes / No If yes, when: _____

Labor and Delivery History:

Birth Weight _____ Birth Height _____

Duration of Labor: _____

Type of Delivery (natural vaginal / C-section): _____

Medications and Anesthesia (types, durations, any reactions):

Were any of the following used?

episiotomy forceps vacuum epidural other: _____

Any complications (none or list)? _____

Fluids-blood loss (how much): _____

Attended by significant other? Yes / No

Held and/or nursed baby on delivery table? Yes / No

APGAR score _____

Any congenital abnormalities (none or list): _____

Father's Profile

Father's Name _____

Age of Father: _____

Present Health Status: _____

Any Prior Medical-Surgical Events (none or list): _____

Are you a smoker? Yes / No If yes, indicate how many cigarettes per day: _____

Do you consume any alcohol? Yes / No If yes, indicate how much per week: _____

Are you working presently? Yes / No If yes, circle FULL-TIME / PART-TIME

What is your stress level? Please rate on a scale of 1 (least) to 10 (most). _____

Child's Profile

A. Medical History:

Any medical conditions (illnesses, injuries, etc.) (If in past, please provide date):

past _____ present _____

Childhood Illnesses:

If child has had any of the following in the past, please provide date of occurrence.

Name	Date
Rubella	
Measles	
Mumps	
Roseola	
Chicken Pox	
Strep Throat	
Rheumatic Fever	
Scarlet Fever	
Impetigo	
Ear Infections (also state how often)	

Current and Past Medications and/or Supplements (indicate brand and dose, for how long):

Vaccination History (check and provide date):

- _ DPT (diphtheria, pertussis, tetanus), when: _____
- _ Tetanus booster, when: _____
- _ MMR (measles, mumps, rubella), when: _____
- _ Polio, when: _____
- _ Flu shot, when: _____
- _ Haemophilus influenza B, when: _____
- _ Hepatitis A, when: _____
- _ Hepatitis B, when: _____
- _ Others: _____

List any adverse reactions:

Accidents and injuries (what and when):

Hospitalizations and surgeries (for what reason and when):

Does your child have any allergies? (medicines, environment, etc.)

B. Feeding/ Nutritional History:

- breastfed for how long: _____
- formula at what age: _____
- what kind of formula (milk, soy, other): _____
- reactions to any formulas? Yes / No If yes, describe: _____

Food Introduction Schedule:

- list foods that were introduced and at which month:

Age of Food Introduction							
Type of Food Introduced							

Diet:

Describe your child's appetite:

Please give a 24-hr diet recall for the child:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Cups of water drank in a day: _____

Food preferences and dislikes? _____

C. Sleeping Patterns:

When does the child go to bed? _____ When does he/she wake up? _____

Does the child wake up in the night? Yes / No If yes, how often: _____

Does your child take naps? Yes / No If yes, how long are naps: _____

D. Developmental milestones:

When did child first: sit up _____ crawl _____ walk _____ talk _____

be fully toilet- trained _____ brush own teeth _____

E. Family History (include chronic, inherited conditions, allergies, causes of death, illnesses):

Relative	Condition(s)
Mother	
Father	
Sibling #1	
Sibling #2	
Sibling #3	
Sibling #4	
Grandparents	
Other	

F. Psychosocial/ Overall Health:

Child's Hobbies and Enjoyed Activities:

How often does your child watch TV/ play video games? (circle day or week) _____ hrs a day / week

Is your child in (check): _ school _ daycare _ other _____

Current School: _____

Grade: _____

How would you describe your child's performance and behaviour at school?

Does your child exercise regularly? Yes / No If yes, what type of exercise, how much and how often:

Home/ Environment Profile

Describe home preparations made for the new baby.

Describe how bringing home a new baby changed the life of each member of the family.

Position of child in family: _____

Number of people in the home: _____

Who is the primary caregiver(s)? _____

Other caretakers for child: _____

Does anyone in the home smoke? Yes / No

Do you know of any toxins or hazards that your child is exposed to regularly (home, hobbies, etc.)?

Any pets in the home? Yes / No If yes, list: _____

How old is the house the family is living in? _____

Has it been recently renovated? Yes / No

Review of Systems

Circle the symptoms child has experienced and put an *N* beside it if currently experiencing it or *P* if in past.

General: headache fever/ chills fatigue/ weakness
 dizziness

Hair and Scalp: dandruff lice cradle cap itchininess hair loss

Skin: infections rashes scaling bruising bleeding

Eyes: infections blurred vision eyeglasses (nearsighted, farsighted)
 squinting color blindness

Ears: infection discharge wax decreased hearing foreign objects

Nose, throat, sinuses: runny nose colds decreased smell foreign objects bloody nose tonsillitis

Mouth and dentition: caries gingivitis cleft lip palate

Respiratory: bronchitis pneumonia asthma cough sputum

Cardiovascular: heart murmurs cyanosis palpitations rheumatic fever

Gastrointestinal: nausea vomiting diarrhea constipation jaundice colic gas anorexia blood in stool

Urinary: increased frequency urgency burning bedwetting odor
blood in urine hesitancy

Male Reproductive: hernias testicular mass testicular pain penile discharge
Female Reproductive: menses vaginal itching vaginal discharge

Neuromuscular: seizures muscle weakness numbness tremors
imbalance

Blood/ Lymphatics: anemia easy bleeding easy bruising swollen lymph node

Emotional: mood swings nervousness depression/ sadness

ADOLESCENCES ADDENDUM (13- 18 yrs)

To be filled out by patient if between the age of 13-18.

Medical History:

What are your health concerns, in order of importance?

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Do you do/ take any of the following (check)?

- smoke, if so, how many packs per (circle) day / week _____
- alcohol, if so, how much and how often _____
- recreational drugs, if so, how much and how often _____
- others _____

Psychosocial:

How would you describe your

- relationship with parents: Excellent Good OK Poor
- relationship with siblings: Excellent Good OK Poor
- relationship with friends: Excellent Good OK Poor

Do you enjoy school? Yes / No

What do you like/ dislike about school?

What is your stress level? Please rate on a scale of 1 (least) to 10 (most) for the following:

Home: _____ School: _____ Other (list): _____

List extra-curricular activities and hobbies: (sports teams, bands, piano lessons, etc.):

List your goals (future goals, career, etc.):

How much TV do you watch? (circle day or week) _____ hrs a day / week

How often do you play video games? _____ hrs a day / week

How often do you use the internet/ computer? _____ hrs a day / week

Do you exercise? Yes / No If yes, what type of exercise, how much and how often:

MALE

Age of onset of puberty: _____

Have you noticed any change in the penis and scrotum? _____

Are you familiar with normal growth patterns, nocturnal emissions ("wet dreams"), and sex education?

FEMALE

When did you notice your breasts were changing? _____

How old were you when you had your first period? _____

Average # of bleeding days (period) _____ Average # of days between bleeding _____

Is there bleeding between periods? _____

Sexual History:

Are you sexually active? Yes / No If yes, please continue.

What type of birth control do you use (none or list)?

Have you been tested for STD's/ venereal diseases? Yes / No If yes, which ones?

Sexual Preference (circle): Heterosexual Bisexual Homosexual

Female: When was your last PAP test? _____

Female: Have you ever been pregnant, had a live birth, miscarriage or abortion?

Is there anything you feel is important that has not been addressed?