

## HEALTH HISTORY

NAME \_\_\_\_\_

SEX  MALE  FEMALE RACE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Please list all people in the household:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father			
Mother			
Other			
Other			
Other			
Other			

Have there been any recent major changes or stresses in the child's life?  YES  NO

If YES, Explain \_\_\_\_\_  
\_\_\_\_\_

Does child go to a baby sitter, preschool or day care regularly?  YES  NO

### BIRTH HISTORY:

Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Place \_\_\_\_\_

During the pregnancy did the mother see a doctor regularly?  YES  NO

During pregnancy did the mother: (If YES, Explain) \_\_\_\_\_ Explanation \_\_\_\_\_

Have any medical problems?  YES  NO \_\_\_\_\_

Smoke or drink?  YES  NO \_\_\_\_\_

Use any medications?  YES  NO \_\_\_\_\_

Use alcohol or other drugs?  YES  NO \_\_\_\_\_

Have problems with labor/delivery?  YES  NO \_\_\_\_\_

How long did the baby stay in the hospital after birth? \_\_\_\_\_

### PAST MEDICAL HISTORY:

Is the child's general health:  GOOD  FAIR  POOR \_\_\_\_\_ Explanation \_\_\_\_\_

Does the child have any allergies?  YES  NO \_\_\_\_\_

Is the child taking any medications?  YES  NO \_\_\_\_\_

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

\_\_\_\_\_  
Date: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_