Medical History Form

Date of Visit_____

Name_____ D.O.B.___/___/___ Age_____

Birth:

Were there any problems during pregnancy? _____ if yes please explain.

_____

_____

Was he/she born more than 2 weeks early? _____if so how early? _____

Were there any complications during delivery? _____ if so what?

_____

_____

Delivery: Natural Forceps Cesarean Section

What was the birth weight? _____

Illnesses:

Please circle all that apply.

Asthma Seasonal Allergies Chicken Pox Diabetes Eczema Pneumonia

Frequent Sore Throat Frequent Ear Infections Seizures

Urinary Tract Infections Kidney or Bladder infections

Other Childhood Illnesses_____

Significant Injuries _____

Hospitalizations (when and reason) _____

Surgery (when and reason) _____

Allergies _____

Are there any behavioral problems? _____

Family:

How is the health of?

Mother: _____

Father: _____

Siblings: _____

Please circle all that apply. Anyone in the family with (close relatives)

Asthma Allergies Diabetes Heart Disease High Blood Pressure

Seizures Thyroid or other Endocrine disorders

Mental Retardation or other Disability

Do you have city water? Yes No

Signature _____ Date _____