

Name (page 2) _____

Personal Health History:

ADHD or ADD	No <input type="checkbox"/>	Yes <input type="checkbox"/>	HIV	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Allergies/Hayfever	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Heart Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anemia	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Kidney or Bladder Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anesthesia Complications	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Liver Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Anxiety Disorder or Recurrent Anxiety	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Migraines	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Asthma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Muscle, Joint, or Bone Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Autism Spectrum Disorder	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Reflux/GERD	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Birth Defects or Inherited Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Seizures/Epilepsy	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Blood Transfusion	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Skin problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cancer	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Stomach Ulcers or Swallowing Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Chicken Pox	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Thyroid Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Clotting Problems - Bleed too much or History of Blood Clots	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Tuberculosis or Positive TB Test	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Developmental or Behavioral Disorders	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Vision or Eye Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Other:	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Domestic Violence	No <input type="checkbox"/>	Yes <input type="checkbox"/>		No <input type="checkbox"/>	Yes <input type="checkbox"/>
Ear Infections - Chronic	No <input type="checkbox"/>	Yes <input type="checkbox"/>		No <input type="checkbox"/>	Yes <input type="checkbox"/>
Ear or Hearing Problems	No <input type="checkbox"/>	Yes <input type="checkbox"/>		No <input type="checkbox"/>	Yes <input type="checkbox"/>
Eczema	No <input type="checkbox"/>	Yes <input type="checkbox"/>		No <input type="checkbox"/>	Yes <input type="checkbox"/>

Does anyone smoke at home? NO YES **Who?** _____

Parents' Marital Status? _____

What is child's current living arrangement?

House Apartment Foster Care Home Other (specify) _____

 Who does child live with? (Circle all that apply) Mother Father Step-Parent Grandparent Aunt/Uncle
 Foster Family Sibling(s) Other _____

Name: (page 3) _____

Prenatal and Birth History

Did this child's mother receive prenatal care? NO YES

Any maternal illness/complications/infections during pregnancy? NO YES _____

Gestational age at birth: _____ weeks

Type of delivery: Vaginal Planned C/S Unplanned C/S Forceps/Vacuum

Reason for unplanned C/S _____

Birth Weight: _____ lbs _____ oz Any complications with delivery? NO YES

Any complications with your child post partum? NO YES _____

Days your child spent in hospital: _____ days

Hearing test: PASSED FAILED UNKNOWN

Nutrition

Was your child breast fed? NO YES If yes, for how long? _____

Any special dietary needs (i.e. Gluten Free)? NO YES _____

Safety

Is your home "child proofed"? NO YES

Type of car seat your child uses: 5-point harness Rear facing Forward Facing Booster

Does your child use helmet for bike/scooter? NO YES

Is there anyone in the house who uses recreational drugs? NO YES

Does your home environment feel safe? NO YES

Do you feel like you need/want help with parenting skills? NO YES

Do you have concerns about meeting basic needs (food/clothing/shelter?) NO YES

Other Questions

Does your child attend Day Care or Preschool? NO YES

Do you feel your child is developing at the same rate as other children? NO YES DON'T KNOW

Do you feel your child interacts normally (like other children) with others? NO YES DON'T KNOW

Name: (page 4) _____

Family Health History

Is your child adopted? Yes / No (If NO, please complete section below)

	Father	Mother	Grandmother	Grandfather	Brother	Sister	Aunt	Uncle
ADHD								
Alzheimer's Disease								
Alcoholism								
Aneurysm								
Anxiety or Depression								
Arthritis								
Asthma								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Manic-Depression or Bipolar								
Migraines								
MI = Heart Attack								
Osteoporosis								
Seizures								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

Thank you!