CHILD MEDICAL HISTORY FORM

Patient Name:			Sex:	□ Male	□ Female	Birthdate/Age:	Date					
Please tell us the reason your child is being seen today:												
		В	irth Hist	tory								
Yes	No	Full Term (37 – 42 weeks)	Yes	No								
		, , , , , , , , , , , , , , , , , , ,			Any complications during pregnancy							
		Premature (weeks)			Preeclampsia/Hypertension/Diabetes							
		Vaginal Delivery			Did Mother smoke/drink during the pregnancy							
		Cesarean Delivery			If yes, how much?							
		Birth Weight lbs Ozs			Did Mother use any drugs/medications during pregnancy							
		APGAR Score:			If yes what kind and how much							
		Jaundice Requiring Medical Treatment			Any complications during the delivery?							
		Length of Hospital Stay			How old was mother at delivery?							
Yes	No	Growth	and Dev Yes	velopment No								
103	110	First Teeth	103	INO	Walked							
		Location:			Spoke First Word							
		Rolled Over			Put Two Words Together							
		Sat Up			Bladder Control in Daytime							
		Stood with Help			Bladder Control in the Night							
		Stood with out Help			Bowel Control							
		•	Diet									
Yes	No		Yes	No								
		Was infant Breast Feed			How much water does your infant/child drink per day			ay?				
		If yes, how long:										
		Is Infant Currently Breast Feeding?			Is your child eating t							
		If yes, how often: If yes, what kinds:										
		Was Infant bottle fed?			Does your child drink milk?							
		If yes, how long?				% Skim						
		Which formula?			Does your child take	e vitamins?						
		Type of water in your house?			If yes, describe:							
		City/ Tap Well Bottled			Does your child take	?						
		Immı	ınization	History			Yes	No				
Is your child up to date on all vaccinations?								110				
Has your child had any adverse reaction to a vaccine, such as fever over 104°, seizure, or other problem?												
If yes, please describe												
Are o	ther chi	ldren living in the household?										
Have any other children had Measles, Mumps, or Rubella?												
							1					



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CHILD MEDICAL HISTORY FORM

Childhood Illness and Medical Problems											
PLEASE mark with and "X: any of the following illnesses and medical problems your child has had											
HINEGO	(())	A CIE	And indica	ate how old the ch	ild was when each star				A GE		
ILLNESS	"x"	AGE		ILLNESS					AGE		
Measles				History of chronic ear infections							
Mumps				How many per year?							
Rubella				At what age did they start?							
Chicken Pox				List any surgeries child has had							
Roseola											
Other, specify: List any broken bones child has had:											
Drug Allergies and Present Medications											
My child is all	ergic to the	following	medications:	My child is currently taking the following medica					1		
				Med	Medication			ge	Frequency		
			Soc	cial and Family	Medical History						
Family	Age	I	Health	Allergies					ns:		
Father					Who does child live	with?					
Mother					List any pets in the house:						
Sibling (M / F)					Is house in: (city / rural, etc)						
Sibling (M / F)					Age of house: (0 – 10 yrs)						
Sibling (M / F)					Any smokers in the house?						
Sibling (M / F)					Does child have a car seat?						
	00				ives have had any of th	ie followin		D. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	I MEMBER		
ILLNE	55	X FAMILY		MEMBER	ILLNESS			FAMILY MEMBER			
Asthma Cystic Fibrosis					Downs Syndrome Mental Retardation						
Muscular Dystro	nhv				Genetic Abnormality						
Phenylketonuria					Sickle Cell Anemia						
Diabetes	(I KU)				Attention Deficit Disorder						
Thyroid Disease at	early age				Alcoholism						
Cancer					Depression: Bipolar	/ Manic					
Leukemia					Any other issues						
Epilepsy											
1 1 1				QUEST	TONS						
YES	NO	Have you	ever been told y	your child has Atte	ention Deficit Disorder	or any oth	er learn	ing disability	by a teacher or		
other professional? If yes, please describe:											
Do you think your child has problems socializing with other children?											
Are there any current legal issues, directly or indirectly affecting/involving your child?											
Has your child been previously treated by a psychologist, psychiatrist or other mental health care provider? If yes, please explain the nature of the problem(s), which the child has seen and indicate when this occurred.											
		If yes, ple	ease explain the	nature of the probl	em(s), which the child	nas seen a	ınd ındi	cate when this	occurred.		
Please add any other comments not covered above:											
1 loade and any other comments not covered above.											