

HISTORY FORM

Name: _____ Date of Birth _____ Sex M F Chart _____

	Name	Age	Health	Miscarriages: Date _____ Weeks _____ Cause _____
Mother	_____	_____	_____	Date _____ Weeks _____ Cause _____
Father	_____	_____	_____	Date _____ Weeks _____ Cause _____
Sibling	_____	_____	_____	
	_____	_____	_____	
	_____	_____	_____	

FAMILY HISTORY	YES	NO	RELATION
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Birth Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____
SIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack < 55 years old	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reflux Esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastric Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pyloric Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip Dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREGNANCY AND BIRTH HISTORY

Illness during Pregnancy Yes No Type _____
 Weeks Gestation _____
 Ob/Gyn _____ Pediatrician _____
 Birth Hospital _____
 Birth Weight _____ Birth Condition _____
 Problems in Hospital _____
 Delivery Method Vaginal C-Section
 Breech Yes No

NUTRITION HISTORY

Feeding: Breast Formula Type _____
 Solids started at _____ months
 Food Intolerances Yes No Type _____
 Herbal Supplements/Vitamins Yes No Type _____

DEVELOPMENTAL HISTORY (age)

Sat _____ Stood _____ Walked _____ Words _____ Short Sentences _____ Toilet Training _____

(continue)

PAST MEDICAL HISTORY

Hospitalization

Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____

Surgery

Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____
Date: _____	Reason: _____	Doctor: _____

PAST MEDICAL HISTORY

	YES	NO
More than 2 ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Urination Problems	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations Up-to-date	<input type="checkbox"/>	<input type="checkbox"/>

PROBLEM LIST (Clinic Use Only)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____