NORTH COAST FAMILY MEDICAL GROUP, INC.
CHILD HISTORY

Today's Date: _____

Parent's names: _____

Name of child: _____ Sex: ☐ M ☐ F Date of Birth:_____

Names and dates of birth for any siblings: _____
_____

Date of child's last physical exam: _____ With who (Dr. or P.A.): _____

MOTHER – (Pregnancy – please answer yes or no)

1. History of miscarriage? _____ If yes, how many? _____
2. Illness during the pregnancy? _____
3. High blood pressure? _____
4. Bleeding/spotting? _____
5. Infections? _____
6. Exposure to toxin, x-ray, etc.? _____
7. Accidents during pregnancy? _____
8. Months pregnant? _____
9. Weight gain? _____
10. How long was labor? _____
11. Method of delivery? (check one)
    ☐ spontaneous ☐ Cesarian ☐ forceps
12. Birth weight? _____

EARLY DEVELOPMENT OF CHILD

1. Did baby cry immediately after birth? _____
2. Was oxygen required for the baby? _____
3. Any problems with sucking or crying? _____
4. Did the baby have:
    ☐ jaundice ☐ twitching
    ☐ rash ☐ convulsions
5. Any congenital abnormality/birthmarks? Please explain:
_____
_____
_____
_____
_____

6. At what age did your child:
    a. Walk with support? _____
    b. Walk without support? _____
    c. Say first word? _____
    d. Put sentences together? _____
    e. Stop wetting during the day? _____
    f. Stop wetting at night? _____
    g. Achieve bowel control? _____

7. Any current problems now in either urinary or bowel control? If so, please explain: _____
_____
_____

FAMILY HISTORY – (Check and give details below if any family member has had):

☐ anemia ☐ bleeding tendency ☐ diabetes ☐ epilepsy ☐ birth defects ☐ mental retardation
☐ asthma ☐ eczema ☐ psychiatric disorders ☐ TB ☐ high cholesterol

Please explain any checked boxes: _____
_____

IMMUNIZATIONS – (Dates) **PLEASE BRING IMMUNIZATION CARD OR RECORD!**

(fill out following if no card available to copy)

1. DPT/DTap _____
2. Polio _____
3. TB skin test _____
4. Measles _____
5. Mumps _____
6. Rubella _____
7. HIB _____
8. Hep A _____
9. Hep B _____
10. Prevnar _____
11. Varicella _____
12. Other _____

MEDICAL HISTORY

1. Childhood infectious diseases: ☐ measles ☐ chickenpox ☐ German measles ☐ mumps
    ☐ whooping cough ☐ scarlet fever ☐ rheumatic fever other _____
2. Has your child had any hospitalizations? If so, when and for what? _____
_____
3. Has your child had any surgery? If so, when and for what? _____
_____

4. Any other serious medical conditions? _____
_____
_____

5. Any head injuries or other serious injuries? _____
_____
_____

6. Has your child had any of the following: ☐ seizures ☐ recurrent headaches ☐ abdominal pains ☐ sleepwalking ☐ night terrors ☐dizziness ☐ staring attacks ☐ muscle jerks ☐ fainting ☐ breath holding ☐ other _____

7. Does he/she take any medications? If so, what and why? (include dosage and frequency) _____
_____
_____

8. Any allergies? _____

SCHOOLING AND TESTS

1. Did you child attend any of the following? ☐ preschool ☐ speech classes
☐ classes for emotionally disturbed children ☐ learning disabilities classes

2. Does your child have any problems with any particular subject? _____

3. In what subject does your child excel? _____

4. What are his/her main interests? _____

5. Does the school feel your child has any difficulties? If so, please explain: _____
_____
_____

6. How much time does your child spend: Watching TV: _____ Computer use: _____ Exercising: _____

7. Has your child had his/her eyes examined? _____ If so, when and by whom? _____

8. Has your child had his/her dental exam? _____ If so, when and by whom? _____

9. Has he/she had a hearing test? _____ If so, when and by whom? _____

10. Any psychological or educational testing? _____ If so, when? _____
By whom? _____

11. Anything else that would be helpful for us to know? _____

_____

_____

_____

_____

_____

_____

_____

Thank you! This form will assist us in using our time together more efficiently. Your time filling it out completely is appreciated!