

**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? _____<br>2. Illness during the pregnancy? _____<br>3. High blood pressure? _____<br>4. Bleeding/spotting? _____<br>5. Infections? _____<br>6. Exposure to toxin, x-ray, etc.? _____ | 7. Accidents during pregnancy? _____<br>8. Months pregnant? _____<br>9. Weight gain? _____<br>10. How long was labor? _____<br>11. Method of delivery? (check one)<br><input type="checkbox"/> spontaneous <input type="checkbox"/> Cesarean <input type="checkbox"/> forceps<br>12. Birth weight? _____ |
|--|--|

**EARLY DEVELOPMENT OF CHILD**

- |  |  |
|--|--|
| 1. Did baby cry immediately after birth? _____<br>2. Was oxygen required for the baby? _____<br>3. Any problems with sucking or crying? _____<br>4. Did the baby have:<br><input type="checkbox"/> jaundice <input type="checkbox"/> twitching<br><input type="checkbox"/> rash <input type="checkbox"/> convulsions<br><br>6. At what age did your child:<br>a. Walk with support? _____<br>b. Walk without support? _____<br>c. Say first word? _____<br>d. Put sentences together? _____<br><br>7. Any current problems now in either urinary or bowel control? If so, please explain: _____<br>_____ | 5. Any congenital abnormality/birthmarks? Please explain:<br>_____<br>_____<br>_____<br>_____<br><br>e. Stop wetting during the day? _____<br>f. Stop wetting at night? _____<br>g. Achieve bowel control? _____ |
|--|--|

**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 _____<br>2. Polio _____<br>3. TB skin test _____<br>4. Measles _____<br>5. Mumps _____<br>6. Rubella _____ | 7. HIB _____<br>8. Hep A _____<br>9. Hep B _____<br>10. Prevnar _____<br>11. Varicella _____<br>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? \_\_\_\_\_  
 \_\_\_\_\_  
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 \_\_\_\_\_

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