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FAMILY AND MEDICAL HISTORY FORM

PART 1: GENERAL INFORMATION

CHILD'S FULL NAME: ________________________________ DATE OF BIRTH: ________________

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers):

PARENT (1) NAME: ________________________________ DATE OF BIRTH: ________________

PHONE NUMBER: ________________________________ EMAIL: ________________________

OCCUPATION: ________________________

HIGHEST EDUCATIONAL LEVEL: ______________________ RELIGION: ____________________

PARENT (2) NAME: ________________________________ DATE OF BIRTH: ________________

PHONE NUMBER: ________________________________ EMAIL: ________________________

OCCUPATION: ________________________

HIGHEST EDUCATIONAL LEVEL: ______________________ RELIGION: ____________________

How did you hear about us?____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD? ____________________

ADDRESS: (optional) ____

PHONE#: ________________________ WHEN IS CHILD IN THIS CHILDCARE? _________

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME	SEX	AGE	RELATIONSHIP TO CHILD

FAMILY STRESSORS (please note if any of the stressful events happened in the last 12 months):

- ☐ Marital separations/divorce
- ☐ Death in the family
- ☐ Financial crisis
- ☐ Job change/difficulties
- ☐ School problems
- ☐ Legal problems
- ☐ Medical problems
- ☐ Household move
- ☐ Extended separation from parents
- ☐ Other stressful event

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PART 2: PREGNANCY AND BIRTH HISTORY

PRENATAL HISTORY:

1. Did you have any problems getting pregnant? Please describe: ______________________________

2. In what month did you begin prenatal care? ______________________________

3. Please list all the over the counter medications taken during this pregnancy and when (i.e., vitamins, antacids, cold medications, aspirin etc.): ______________________________

4. Please list any cigarettes, caffeine, street drugs taken (how much a day and when in pregnancy): _____ ______________________________

5. Please list all the prescription medications taken (name, dosage and from when to when): ___________ ______________________________

6. Did you have any of the following events occur during this pregnancy?

- ☐ Allergies or asthma
- ☐ Anemia
- ☐ Diabetes
- ☐ Edema (swelling, water retention)
- ☐ Excessive vomiting
- ☐ Headaches/migraines
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Pre-eclampsia
- ☐ Rh negative
- ☐ Toxemia
- ☐ Toxin exposure
- ☐ Accidents
- ☐ Bleeding/spotting
- ☐ Blood transfusions
- ☐ Cervical incompetence
- ☐ Infections (bladder or genital)
- ☐ Infections (other)
- ☐ Pre-term labor
- ☐ Uterine or uterine fluid problems
- ☐ Other physical injury
- ☐ Other not specified problem____________ ________________

BIRTH HISTORY (for the child being evaluated):

1. Hospital where born: ______________________________

2. Physician's Name: ______________________________

3. Gestational age at time of delivery (or # weeks early or late): ______________________________

4. Length of Labor (in hours)? ____________________

5. What type of delivery (please circle)? Vaginal Cesarean Section -- Elective or Emergency

   Presentation: Head, Face, Breech, or Transverse Reason for C-section _______________

   Assistance: Forceps, Vacuum, other _______________Pitocin (in hours)? _______________

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6. Did you experience any of the following problems during the labor/delivery?

- ☐ MATERNAL infection
- ☐ Low/high red/white blood cell count
- ☐ Pelvis or cervical problems
- ☐ Placenta problems
- ☐ Dysfunctional labor
- ☐ BABY had the cord around the neck
- ☐ Cord problems (knots, prolapsed, compression)
- ☐ Baby had very low or high heart rate
- ☐ Baby had heart rate decelerations
- ☐ Fetal distress was noted
- ☐ Meconium was noted

7. How soon after the delivery did you see your baby ______________________________

8. What was the baby's APGAR scores? 1 minute ______________ 5 minute ________________

9. What was the baby's Birth Weight? ______________ Birth Length ________________________

10. Number of Days spent in the nursery? ________________NICU or Newborn Nursery? _________

11. What was the condition of your infant while in the nursery?

- ☐ Was blue/cyanotic
- ☐ Required stimulation to breathe
- ☐ Required oxygen
- ☐ Required resuscitation
- ☐ Small for gestational age
- ☐ Tremoring/seizures
- ☐ Very low tone
- ☐ Brain hemorrhage
- ☐ Anemia and/or transfusions
- ☐ Jaundice (yellow)
- ☐ Had bruising
- ☐ Rh incompatibility
- ☐ Infections
- ☐ Congenital birth defects
- ☐ Aspiration (meconium or fluid)
- ☐ Respiratory distress signs or syndrome
- ☐ Needed ventilation
- ☐ Choking or vomiting episodes
- ☐ Tube feedings
- ☐ Needed medications

FEEDING HISTORY

Describe your child's feedings briefly from birth, noting any difficulties (breast/bottle fed, weaned when, introduced solids/table foods, colic/food allergies, growth/nutrition problems, feeding problems (skip if completing "Feeding History From")

____

____

____

____

____

PART 3: MEDICAL HISTORY OF CHILD

- ☐ Frequent colds/ Respiratory illness
- ☐ Frequent strep throat/sore throat
- ☐ Frequent ear infections
- ☐ PE tubes
- ☐ Birth defect/genetic disorder
- ☐ Lung condition/ respiratory disorder
- ☐ Allergies or asthma
- ☐ Heart condition
- ☐ Anemia/blood disorder
- ☐ Kidney/renal disorder
- ☐ Urinary problems/ infections
- ☐ Hormonal problem
- ☐ Muscle disorder/muscle problem
- ☐ Joint or bone problems
- ☐ Fractured bones
- ☐ Skin disorder/skin problems (eczema)
- ☐ Visual disorder/vision problems
- ☐ Eye infections
- ☐ Neurological disorder
- ☐ Seizures or convulsions
- ☐ Stomach disorder/stomach pain
- ☐ Vomiting/digestion problems
- ☐ Failure to gain weight/feeding problems
- ☐ Constipation/diarrhea problems
- ☐ Dehydration episodes
- ☐ Hearing loss/Ear disorder
- ☐ Significant accidents
- ☐ Head injuries or concussions
- ☐ Ingestion of toxins, poisons, foreign objects
- ☐ Major medical procedures
- ☐ Chronic medications (for what? when?)
- ☐ Any major childhood illness (pox, croup, measles, mumps, meningitis etc.)

Has your child's hearing been evaluated? [ ] Yes [ ] No When? _________ Results? ______________

HOSPITALIZATIONS AND/OR SURGERIES:

List the dates of any hospitalizations your child has had and the reason.

1. ____
2. ____
3. ____
4. ____

PRESENT HEALTH STATUS: Most recent Height = _________ Weight = ____________

Please note any illnesses for which your child is currently being treated, incl. their current medications:

____

____

____

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PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you do not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time, or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE		GOOD/FAIR	POOR
Smiled							
Held head up							
Rolled over							
Reached for an object actively							
Transferred object between hands							
Sat unsupported							
Crawled							
Stood alone							
Walked by self							
Said first words							
Threw objects actively							
Ran by self							
Followed simple 1 step directions							
Said 2-3 phrases							
Ate unaided with a spoon/fork							
Dressed self							
Rode bicycle without training wheels							
Caught a thrown object							
Demonstrated handedness (which?)							
Knew colors							
Counted to 5							
Knew alphabet							
Bladder trained - days							
Bladder trained - nights							
Bowel trained							

Behavioral Characteristics:

☐ Cooperative
☐ Restless
☐ Attentive
☐ Poor eye contact
☐ Willing to try new activities
☐ Easily distracted/short attention
☐ Plays alone for reasonable length of time
☐ Destructive/aggressive
☐ Separation difficulties
☐ Withdrawn
☐ Easily frustrated/impulsive
☐ Inappropriate behavior
☐ Stubborn
☐ Self-abusive behavior

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1. Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain:

____

2. If your child is in school, please describe any difficulties or strengths in reading, writing or spelling:

____

3. Name of current school: ______________________ Grade: ____________________

Any special educations services (which, when)?________________________________

Teacher:____

Describe any other concerns shared by the teacher: ____________________________

____

5. Has your child had problems with any of the following (beyond expected for child's age):

- ☐ Sleeping problems
- ☐ Bed wetting
- ☐ Drooling
- ☐ Thumb sucking
- ☐ Temper tantrums
- ☐ Head banging
- ☐ Breath holding
- ☐ Aggression/destructive behaviors
- ☐ Nervous habits (nail biting etc.)
- ☐ Masturbation
- ☐ Fire play or cruelty to animals
- ☐ Major mood swings
- ☐ Under or over reactive to sounds
- ☐ Under or over reactive to clothing
- ☐ Under or over reactive to taste
- ☐ Under or over reactive to smell
- ☐ Any unusual fears?

PART 5: FAMILY MEDICAL HISTORY

Is there family history of any of the following medical problems?

- ☐ Birth defects/Congenital disorder
- ☐ Neurological disorder or seizures
- ☐ Respiratory disease or tuberculosis
- ☐ Hormonal or Gland disorder
- ☐ Allergies - food or environmental
- ☐ Diabetes
- ☐ Stomach disease/disorder/problems
- ☐ Senses problems - vision, hearing, touch, taste, smell, balance
- ☐ Swallowing or feeding problems
- ☐ Anorexia/Bulimia
- ☐ Attentional/learning problems
- ☐ Hyperactivity
- ☐ Alcohol/drug problems
- ☐ Psychologic