

Medical History

Child's Name: _____

Date of Birth _____

Allergies: _____

1. Birth weight: _____ Length: _____

2. Type of delivery (check one)

_____ vaginal _____ C-section

3. Length of hospital stay after delivery: _____

4. Did baby have any problems while in the hospital? _____ Yes _____ No

5. Are your child's immunizations up to date? _____ Yes _____ No

6. Does your child have any of these medical problems?

_____ Asthma _____ Heart Disease
_____ Diabetes _____ Kidney Disease
_____ Sickle Cell Disease _____ Other (please specify)
_____ Tuberculosis _____
_____ Seizures (Convulsions) _____
_____ Mental Retardation _____

7. Are there any medical problems that run in your family?

8. Has your child ever been hospitalized? _____ Yes _____ No

If Yes, please reply: _____

9. Has your child ever had surgery? _____ Yes _____ No

Please specify: _____

Developmental History

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. At what age did your child talk? _____
4. At what age was your child potty trained? _____

Physician Signature