

MEDICAL HISTORY of _____ Birth date: _____

Please complete this so that we may know how to best serve you, your family, and your child.

- I. Family History: Is this child adopted? Yes No in "foster care" now? Yes No
In foster care in the past? Yes No
In "kinship care now? Yes No In "kinship" care in the past? Yes No

Who lives in your house? Please provide name, age, education completed, and job or skills of each person

II. This Child's Medical history:

A. Mother's history during pregnancy: Blood type _____

Mother's Age at delivery _____ yrs. Number of pregnancies _____ Number of live births _____

Problems during pregnancy : None / Yes: _____

B. Birth: Type of delivery: Vaginal / C-section On time / Premature Weeks gestation _____

Length _____ inches Weight _____ lbs _____ oz

Problems after birth: None / Yes: _____

C. Date of last check up: _____ Name of Dr / Practice _____

Phone # / Address _____

D. Please list all operations, hospitalizations, physical and mental health problems, accidents, injuries, ER visits:

E. If your child or family member has ever had any of the following, please circle it:

.....None

- | | | | | |
|----------------|----------------|---------------------------|---------------|-------------------|
| AIDS or HIV | Anemia | Arthritis | Asthma | Bladder infection |
| Cancer | Chickenpox | Diabetes | Diphtheria | Eczema |
| Epilepsy | Heart disease | Hepatitis (liver disease) | Hernia | Kidney disease |
| Lead Poisoning | Leukemia | Lung infections | Measles | Mononucleosis |
| Mumps | Pneumonia | Rheumatic Fever | Scarlet Fever | Thyroid disease |
| Tuberculosis | Whooping cough | Other: _____ | | |

F. Diet: Does your child eat / drink: (Circle appropriate items please)

Breast milk / 1%, 2%, chocolate, strawberry, whole milk / formula? How many times / day? _____

Juice (which kind? _____) How many times / day? _____

Water - tap / bottled, no fluoride / bottled with fluoride (circle those used) How many times / day? _____

Soda (which kinds? _____) How many times / day? _____

Meats / eggs / beans / poultry / fish / peanut butter (circle those eaten) How many times / day? _____

Vegetables - which ones? _____ How many times / day? _____

Fruits - which ones? _____ How many times / day? _____

Breads / cereals - which ones? _____ How many times / day? _____

How many times a week do you eat "fast food" or "eat out"? _____

Does your family or child have any special diets or food preferences? Yes No
If yes, please describe

G. Development / Education: What school does your child attend? _____ Grade _____
Achievement: A's B's C's D's F's Outstanding / Satisfactory / Unsatisfactory Honor Roll / Merit Roll / trouble
Do you have concerns that your child's development is not normal? Yes No
speech development / coordination / writing / drawing / social skills / bullying
School performance: math / science / social studies / writing / behavioral

H. Has your child ever participated in: (Circle all that apply)
Clubs / After school sports / Bilingual programs / Emotional support classes / Day care
Learning support classes / Gifted/Talented programs / Speech therapy / Headstart / Evenstart / Life skills class'
Special education program / Organized activity (scouts, leagues, etc)

I. Habits:
Does your child ever wet the bed or their pants - nighttime or daytime? Yes No
Does your child soil their pants - daytime or nighttime? Yes No
Do you read with your child every day for at least 30 minutes? Yes No
What is your bedtime routine with your child?

J. Health / fitness:
How many TVs ___VCRs ___ DVD players___ Computers___ are there in your home? In child's bedroom? Yes No
How much time" does your child have daily (TV, VCR, DVD, computer games, internet access)? _____ hrs
Does your child leave on light, music, or TV when they sleep? Yes No
Do they cough, snore, or have breathing difficulty at night? Yes No
Do you know anyone who smokes cigarettes? Yes No
uses marijuana, cocaine, heroin, or other illegal substances? Yes No
What does your child do for exercise? _____
What weekend activities does your child participate in? _____
What activities do you enjoy as a family? _____

K. Safety:
Does your child "Stop, Look, and Listen" before crossing the street?..... Yes No
Wear a seat belt always when in a vehicle? Yes No
Sit in a car seat or booster seat? Rear facing / front facing (circle one) Yes No
Wear a helmet (and knee and elbow pads) when riding a bike?..... Yes No
when skateboarding?.....Yes No
Are weapons (guns and knives) in your home and your child's daycare home secured away from children? Yes No
Is ammunition stored separate?Yes No
Is there peeling, flaking, or chewed paint in your home, stairway, or play areas?..... Yes No
Does your family have and practice a fire evacuation plan in case of emergency? Yes No
Have you ever been hurt physically or emotionally by someone?..... Yes No
Are you concerned that someone might hurt you physically or emotionally?..... Yes No
Are medicines stored locked and away from children?..... Yes No

L. Other:
Have you considered organ donation? Would you like more information?..... Yes No
Do you have a living will (about what you want done with your body if you should die)? Yes No
Would you like more information? Yes No
Do you have questions for us that you want to write here so that they won't be forgotten?..... Yes No