

LANDEN LAKE PEDIATRICS

CHILD'S NAME _____

BIRTH _____

History to be Filled Out by Parent

A. PREGNANCY AND BIRTH:

- | | | |
|---|-------|-----|
| 1. Did you have an illness during your pregnancy? | No | Yes |
| 2. Did the baby come on time? | Yes | No |
| 3. What was the birth weight? | _____ | |
| 4. Did your baby have any trouble starting to breathe? | No | Yes |
| 5. Did the baby have any trouble while in the hospital? | No | Yes |

B. FEEDING AND DIGESTION:

- | | | |
|---|-------|-----|
| 1. Was there severe colic or any unusual feeding problems the first 3 months? | No | Yes |
| 2. Is your child's appetite usually good? | Yes | No |
| 3. Is it good now? | Yes | No |
| 4. Do any foods disagree with him/her? | No | Yes |
| 5. Does he/she often have diarrhea? | No | Yes |
| 6. Has constipation ever been much of a problem? | No | Yes |
| 7. Does he/she take vitamins? | Yes | No |
| 8. If still on formula, what one do you use? | _____ | |

C. FAMILY HISTORY:

- | | | |
|--|----------------|-----|
| 1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters have had: Tuberculosis, Diabetes, Asthma, Allergy, Seizures, Cancer, Mental Illness, Inherited Diseases. | | |
| 2. Are the child's parents both in good health? | Yes | No |
| 3. List ages, sex and general health of brothers and sisters: | _____
_____ | |
| 4. Have any of your children died? | No | Yes |

D. INFECTIONS, ILLNESSES, MISCELLANEOUS PROBLEMS AND DEVELOPMENT:

- | | | |
|---|-------|-----|
| 1. Has your child had as many as three bouts of ear trouble? | No | Yes |
| 2. Does he/she usually have more than three colds or throat infections a year with fever? | No | Yes |
| 3. Does he/she have any trouble with urination? | No | Yes |
| 4. Has he/she ever had a convulsion? | No | Yes |
| 5. Does he/she hear well? | Yes | No |
| 6. Has he/she had any trouble with his/her eyes? | No | Yes |
| 7. At what age did he/she sit alone? | _____ | |
| 8. At what age did he/she walk alone? | _____ | |
| 9. Did he/she say any words by the time he/she was 1 1/2 years old? | Yes | No |

- | | | |
|--|----|-----|
| 10. Does he/she have any trouble sleeping now? | No | Yes |
| 11. Are there any problems with his/her teeth? | No | Yes |
| 12. Circle any of the following that your child has had:
"red" or "hard" measles pneumonia
whooping cough broken bones
German or "3-day" measles
serious accidents
removal of tonsils and adenoids
Other operations _____
Other diseases—what? _____
Hospitalization—for what? _____ | | |

E. ALLERGIES:

- | | | |
|--|----|-----|
| 1. Has he/she ever had exzema or hives? | No | Yes |
| 2. Has he/she ever had wheezing or asthma? | No | Yes |
| 3. Does he/she tend to have a stuffy nose or "constant cold?" | No | Yes |
| 4. Has he/she had any allergies or reactions to any medicines or injections? | No | Yes |

F. EMOTIONAL PROBLEMS:

- | | | |
|---|-----|----|
| 1. Is he/she doing well in school? | Yes | No |
| 2. Does he/she get along well with other children? | Yes | No |
| 3. Underline any of the following which your child has:
nail biting thumbsucking
nightmares bad temper
Irritable wets bed
won't mind can't toilet train
speech problems breath holding
jealousy | | |

G. TEST AND IMMUNIZATIONS:

- | | | |
|---|-----|----|
| 1. Has he/she had the "DPT" or diphtheria, tetanus, and whooping cough vaccine? | Yes | No |
| 2. His/her last DPT booster date: _____ | | |
| 3. Has he/she had all 3 doses of polio vaccine by mouth? | Yes | No |
| 4. Has he/she had measles vaccine? When? _____ | Yes | No |
| 5. Has he/she had a skin test for tuberculosis? When last? _____ | Yes | No |

H. ANYONE SMOKE AT HOME? yes no

Please complete one yellow sheet for each child.