

INFORMATION PROVIDED BY PARENT OR GUARDIAN OF \_\_\_\_\_

**PREGNANCY**

- |   |     |    |
|---|-----|----|
| 1. Has Mother ever had a miscarriage?                   | Yes | No |
| 2. Was there any illness during the pregnancy?          | Yes | No |
| 3. Was there any medication taken during the pregnancy? | Yes | No |
| 4. Did mother smoke during the pregnancy?               | Yes | No |

**DELIVERY**

- |   |     |    |
|---|-----|----|
| 1. Was the baby early/late? If so, how many days? _____                             | Yes | No |
| 2. How much did the baby weigh? ___Lb. ___Oz.                                       | Yes | No |
| 3. Did the baby have any problems while in the hospital?<br>If yes, describe: _____ | Yes | No |
| 4. Did the baby have jaundice?  | Yes | No |

**FEEDING AND DIGESTION**

- |   |     |    |
|---|-----|----|
| 1. Did your baby have any feeding problems during the first three months of life? | Yes | No |
| 2. Has your child had any difficulties with weight or growth?                     | Yes | No |
| 3. Does your child have frequent bouts of diarrhea?                               | Yes | No |
| 4. Does your child have problems with constipation?                               | Yes | No |

**FAMILY HISTORY**

*Please circle any of the diseases that this child's natural parents, grandparents, aunts, uncles, sisters, or brothers have had:*

- |               |                 |                    |                            |
|---------------|-----------------|--------------------|----------------------------|
| Diabetes      | Seizures        | Tuberculosis       | Lupus                      |
| Heart Disease | Cancer          | Mental Illness     | Thyroid Disease            |
| Allergy       | Asthma          | Mental Retardation | Inflammatory Bowel Disease |
| Deafness      | Cystic Fibrosis | Bleeding Disorder  |                            |

Other: \_\_\_\_\_

**MEDICAL HISTORY AND DEVELOPMENT**

*Please circle any illnesses or problems this child has ever had.*

- |                          |                    |              |
|--------------------------|--------------------|--------------|
| Recurrent Ear Infections | Inhalent Allergies | Hives        |
| Recurrent Colds          | Food Allergies     | Eczema       |
| Asthma                   | Drug Allergies     | Impetigo     |
| Urinary Tract Infection  | Convulsions        | Roseola      |
| Heart Disease            | German Measles     | Mumps        |
| Rhuematic Fever          | Scarlet Fever      | Pinworms     |
| Red Measles              | Delayed Walking    | Strep Throat |
| Emotional Problems       | School Problems    | Bed Wetting  |

Other: \_\_\_\_\_