INTERLACHEN PEDIATRICS Today's Date: _____

Patient Name _____ Date of Birth _____

Birth Weight _____ lbs._____oz. Delivery: Vaginal or Cesarean Section (Circle One)

PREGNANCY AND BIRTH HISTORY:

1. Did mother have any illnesses or problems during pregnancy? ..... Y N
2. Did mother take any drugs or medications during pregnancy other than iron or vitamins? ..... Y N
   If yes, what?_____
3. Did mother drink ANY form of alcohol during pregnancy? ..... Y N
4. Were there any ABNORMAL tests during pregnancy? (blood tests, ultrasounds, etc.) ..... Y N
5. Did the baby arrive early or late? If yes, how many weeks? ..... Y N
6. Were there any problems at the delivery? ..... Y N
7. Did the baby have any problems? (breathing problems, jaundice, cyanosis, etc) ..... Y N
   If yes, explain: _____

PATIENT'S PAST HISTORY:

8. At what age did your child roll over?_____, sit?_____, stand?_____, walk?_____, start talking? _____, become toilet trained? _____
9. Has your child had more than (4) ear infections? ..... Y N
10. Does your child usually have more than (5) colds or sore throats each year? ..... Y N
11. Does your child usually get an ear infection after a cold? ..... Y N
12. Does your child seem to have a continuous "stuffy" nose or constant cold? ..... Y N
13. Has your child had "asthma" or "wheezing" more than (2) times? ..... Y N
14. Has had your child had any feeding or gastrointestinal problems? ..... Y N
15. Has your child had any problems with urination or urinary tract (kidney) infections? ..... Y N
16. Has your child had any heart problems? What?_____ ..... Y N
17. Has your child ever had a convulsion or seizure? ..... Y N
18. Has your child had any visual or eye problems? ..... Y N
19. Has your child had any ALLERGIC REACTIONS TO MEDICATIONS? What?_____ Y N
20. Have any of your children died? ..... Y N
21. Has your child ever been hospitalized or had any surgery? What?_____ Y N
22. Does your child have any other medical or psychological problem that we should know about? ..... Y N
    What?_____

FAMILY HISTORY: Please list any family members that have the following problems; include parents, grandparents, aunts, uncles and cousins. ANSWER AS IF ANSWERING FOR YOUR CHILD.

AIDS (+HIV test)_____
Depression_____
Thyroid Probs_____
Diabetes_____
Cancer/Leukemia_____
Crib Death (SIDS)_____
Sinus Probs_____
Inherited Disorders_____
Sickle Cell Anemia (or Trait)_____
Early Deafness_____
Anemia_____
Bleeding Probs_____
Migraines_____
Asthma_____
Allergies/Hay Fever_____
Eczema_____
Cystic Fibrosis_____
Lupus_____
Tuberculosis (TB)_____
Alcohol Prob_____
Drug Probs_____
Psychiatric Probs_____
Seizures/Epilepsy
Kidney Prob (& infections)_____
Lazy Eye_____
Rheumatoid Arthritis_____
Other _____

Mark an " X" in the box to all that apply

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling 1	Sibling 2
Obesity								
Cardiovascular Disease								
High Blood Pressure								
Stroke								
High Cholesterol								
High Triglyceride								
Type 1 or 2 Diabetes								

Mother's Age: _____ Father's Age: _____ Married Divorced Other *(Circle one)*

Who lives at home with the child? _____