AGOURA-WEST VALLEY PEDIATRIC MEDICAL GROUP

Child's Family Background

Names and ages of any living brothers and/or sisters

_____ _____
_____ _____
_____ _____
_____ _____

Death of a parent, brother or sister? yes ☐ no
If yes, cause: _____
Was child adopted? yes ☐ no
If yes, at what age? _____

Pregnancy and Birth History

How many previous pregnancies? _____
How many miscarriages? _____
What month of pregnancy did you start doctor's care? _____
Were there any illnesses during pregnancy for which medications were prescribed or taken?
yes ☐ no
If yes: Month of pregnancy _____
Name(s) of medication(s) _ _____
_____
Were there any illnesses or complications during pregnancy?
yes ☐ no
If yes, what type?_____
_____

Mother's estimated length of pregnancy in weeks?
(40 weeks = full term) _____ weeks

Child's birth weight_____ lbs _____ oz

Was this a breech delivery (feet or bottom first)?
yes ☐ no
Was the baby a Cesarean delivery/surgery?
yes ☐ no

In the nursery was the baby…

On oxygen? yes ☐ no

On a ventilator? yes ☐ no

Under bilirubin lights (phototherapy)? yes ☐ no
If yes, how many hours?_____ or days _____

Baby is (was) ……. Breast-fed Bottle-fed

If bottle-fed, what kind of formula? _____

Family History: If any blood relatives have ever had any of these conditions, please check 'mother, father, sister, brother' and if relative please check mother's side or father's side.

	Mother	Mother's Side	Father	Father's Side	Brothers	Sisters
Any bleeding diseases?						
Sickle Cell Diseases?						
Cystic Fibrosis?						
Thyroid conditions?						
Bone disease?						
Deafness before age 50?						
Color blindness?						
Cystic kidney?						
Diabetes?						
Epilepsy (convulsions) seizures?						
Migraine headaches?						
Asthma, eczema or allergies?						
Depression/Anxiety?						
Attention Deficit Disorder (ADD)?						
Genetic/birth defects?						
Heart conditions?						
Heart attack before age 50?						
Cancer?						
Developmental Delay?						
High blood pressure?						
High cholesterol?						
Auto-immune disorders?						
Strokes/clotting disorders?						
Serious Medical Conditions?						

****FOR NEWBORNS STOP HERE****

Feeding History

Was (is) the baby allergic to or intolerant of any foods?
yes ☐ no
If yes, which foods? _____
Does the child eat meat, fruit, vegetables and drink milk now?
☐ yes ☐ no

Vaccinations

Is your child up to date on immunizations? _____
Have you chosen to omit any vaccines? _____
If so, which ones and for what reason?
_____

CONTINUED OVER

AGOURA-WEST VALLEY PEDIATRIC MEDICAL GROUP

Growth and Development

At what age did your child (omit if too young)

Sit unsupported (alone) _____months

Walk alone _____months

Talk in two-word sentences _____months

Has your child had any of the following?

Pneumonia	yes no
Heart trouble	yes ☐ no
Kidney disease	yes ☐ no
Convulsions/Seizures	yes ☐ no
Asthma	yes ☐ no
Eczema/Sensitive skin	yes ☐ no
Chickenpox	yes ☐ no
Appendicitis	yes ☐ no
Whooping Cough	yes ☐ no
Anemia	yes ☐ no
Bladder infection	yes ☐ no
Other serious illness	yes ☐ no

If yes, please list: _____

_____

_____

_____

Has your child ever had (been)

Tonsil-Adenoid surgery?	yes ☐ no
Broken bones?	yes ☐ no
Other serious Injuries?	yes ☐ no
Unconscious from an injury?	yes ☐ no
Treated for accidental poisoning?	yes ☐ no

Hospitalized for reasons other than those listed above?
yes ☐ no

If yes, please list: _____

_____

Please list any medications your child takes on a regular basis.

_____ _____

_____ _____

Is your child allergic to or intolerant of :

Medications ☐	yes ☐ no
Foods ☐	yes ☐ no
Other items ☐	yes ☐ no

If yes, please list:

_____ _____

_____ _____

Has your child had:

Headaches more than twice a month? ☐	yes ☐ no
Frequent bad stomachaches? ☐	yes ☐ no
Frequent vomiting? ☐	yes ☐ no
Fainting spells? ☐	yes ☐ no
Trouble hearing? ☐	yes ☐ no
More than three ear infections in a year? ☐	yes ☐ no
More than six colds in a year? ☐	yes ☐ no
Stuffy nose most of the time? ☐	yes ☐ no
Shortness of breath with exercise? ☐	yes ☐ no
Chronic cough/frequent bronchitis? ☐	yes ☐ no
Heart murmur? ☐	yes ☐ no
Frequent spells of diarrhea? ☐	yes ☐ no
Bleeding with bowel movements? ☐	yes ☐ no

Frequent bedwetting after the age of five years? ☐ yes ☐ no

Frequent urination? ☐	yes ☐ no
Loss of urinary bladder control? ☐	yes ☐ no
Bloody, red or brown urine? ☐	yes ☐ no
Frequent nightmares? ☐	yes ☐ no
Inability to get to sleep? ☐	yes ☐ no

Weak eye muscles (cross eyes or wall eyes)? ☐ yes ☐ no

Are there problems with the child's behavior in the home?

☐ yes ☐ no

If yes, please explain: _____

_____

_____

If child is old enough for school, are there any school problems (learning, social, behavioral, coordination)?

If so, please explain: _____

_____

_____