Birth History:

Was pregnancy normal or difficult?	Normal	Difficult
Was delivery normal or difficult?	Normal	Difficult
Was the baby full term	Yes	No
Did the baby have an problems in the nursery?	Yes	No
Any problems in the first month of life?	Yes	No

Indicate- any of the following problems your child has had:

( ) Skin trouble	( ) Constipation	( ) Lung Problems/Asthma
( ) Eye Problems	( ) Urinary Infections	( ) Heart Murmur or Disease
( ) Frequent Ear Infections	( ) Menstrual Cramps	( ) Feeding Problems
( ) Hearing Problems	( ) Anemia	( ) Frequent Headaches
( ) Chronic Nasal Congestion	( ) Joint Pain/Swelling	( ) Behavioral Problems
( ) Frequent Sore Throats	( ) Seizures	( ) Sleep Problems
( ) Pneumonia	( ) Chicken Pox	( ) Developmental Problems

( ) Other _____

Family History-check any of the following illnesses in relatives (parents, siblings, grandparents, aunts, uncles and cousins)

( ) Eczema	( ) Obesity	( ) Alcoholism/Drug Abuse
( ) Asthma	( ) Birth Defects	( ) Kidney Disease
( ) Allergies/Hayfever	( ) TB/Lung Disease	( ) Cancer
( ) High Blood Pressure	( ) Headaches	( ) Cystic Fibrosis
( ) Heart Attack or Stroke Under 55 years of age	( ) High Cholesterol or Triglycerides	( ) Mental Retardation
		( ) Psychiatric Problems
( ) Diabetes	( ) Anemia/Blood Problems	( ) Ulcers/Colitis
( ) Thyroid Disease	( ) Smoking	

Social History-

What are your child's favorite pastimes? _____

How is your child doing in school? _____

How does your child get along with other children? _____

Are there any interpersonal or family problems, which you are concerned about and wish to discuss with the doctor? Yes____ No____

Preventative Care-

Are there any firearms in your home?	Yes	No
If yes are they locked and unloaded?	Yes	No
Do you wear seat belts/car seats 100% of the time?	Yes	No
Do you have the poison control number in your phone?	Yes	No
Do you have smoke detectors in your home?	Yes	No
Does anyone who lives in the home with your child smoke cigarettes	Yes	No
If yes, talk to your doctor about how we can help you reduce the risks of smoke exposure.		
Are there any concerns you have about the safety of you or your child in your home? (list)	Yes	No

Are there any other problems about your child which concern you? (list) _____