Histories

CHILD **MEDICAL**

past concerns______________________________

hospitalizations/surgery/medications______________________________

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IMMUNIZATION: (Please circle those received)

Rotavirus Hepatitis B Pneumococcal Hemophilus B Pertussis Polio Hep A

Gardisil Measles Mumps Rubella Tetanus Influenza Dephtheria

Adverse reactions?______________________________

ALLERGENS: (Please circle)

past experiences: eczema hives wheezing asthma stuffy nose (constant cold)

known allergies to: Medications? Injections? Food? (if yes to any, please detail)

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FAMILY

	Age	General Health	Specific Disease
Mother			
Father			
Siblings			
Grandparents			

PRENATAL Difficulties: (Please circle those experienced)

gestational diabetes thyroid conditions nausea/vomiting emotional trauma

physical trauma high blood pressure toxemia bleeding nutritional deficiencies

weight gain stress infections

Mother's Exposure: Please X and detail 'Yes' answers

	No	Yes	Detail
Alcohol			
Drugs (recreational/smoking)			
Medications/Supplements			
Toxins			
Diseases			

BIRTH

Did baby deliver on time? Yes No (If no, + weeks = _________or – weeks =__________)

Delivery Method? Hospital / Other (explain):______________________________

Number of pregnancies ______________________ Number of Miscarriages________________

Any interventions? Pain medications / epidural / forceps / vacuum / pitocin / other___________

Length of Labor______________ Spontaneous?__________ Induced?__________

Caesarean? Yes / No Birthweight (lbs.):____________ length:_______________

Head circumference:____________________ Apgar Score:_____________________