

C. FAMILY HISTORY

1. Are the child's parents in good health? NO YES

Circle any diseases that this child's parents, grandparents, brothers, sisters, and/or aunts and uncles have had:

- | | | |
|---------------------|------------------|-------------------|
| Anemia | Heart Trouble | Inherited Illness |
| Allergies | Tuberculosis | Venereal Disease |
| Diabetes | Mental Illness | Cancer |
| High Blood Pressure | Alcohol Problems | AIDS |
| Drug Problems | | |

Other _____

List General Health of Brothers and Sisters Below

- | | | |
|----------------------|------------------|----------------------|
| 1. First Name: _____ | Last Name: _____ | Date of Birth: _____ |
| 2. First Name: _____ | Last Name: _____ | Date of Birth: _____ |
| 3. First Name: _____ | Last Name: _____ | Date of Birth: _____ |
| 4. First Name: _____ | Last Name: _____ | Date of Birth: _____ |
| 5. First Name: _____ | Last Name: _____ | Date of Birth: _____ |

General Health Status

1. _____
2. _____
3. _____
4. _____
5. _____

Are any children deceased? NO YES

D. FEEDING AND NUTRITION

1. Is appetite usually good? NO YES

Note any problems _____

2. Is child still on formula, which one is used? _____

3. Does child take vitamins? NO YES

E. REVIEW OF SYSTEMS

- | | |
|---|--------|
| 1. Has your child had frequent ear infections? | NO YES |
| 2. Any eye problems? | NO YES |
| 3. Has he/she had any problems with teeth? | NO YES |
| 4. Does he/she have frequent colds or sore throats? | NO YES |
| 5. Is there asthma, pneumonia, or a recurrent cough? | NO YES |
| 6. Does he/she have a heart murmur or any heart problems? | NO YES |
| 7. Any problems with urination? | NO YES |
| 8. Any problems with diarrhea or constipation? | NO YES |
| 9. Have there been any convulsions or other problems with the nervous system? | NO YES |
| 10. Any eczema, hives, or other skin conditions? | NO YES |
| 11. Has your child ever been anemic? | NO YES |

12. Please list any other medical problems _____

F. DEVELOPMENT/BEHAVIOR

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1 1/2 years old? NO YES
4. At what age did your child start putting words together? _____
5. How does this child compare to others his or her age? _____
6. Does he/she have any trouble sleeping? NO YES
7. What grade is he/she in? _____
8. Has he/she had any trouble in school? NO YES
9. Does he/she get along with other children? NO YES
10. Circle if your child has had any of the following:
Nail Biting Bad Temper Hyperactivity Thumb Sucking
Problems with Toilet Training Nightmares Bed Wetting
Problems with Discipline Speech problems
Other _____
11. Does your child have any special needs? NO YES (Please detail on reverse side)

G. SAFETY/ENVIRONMENT

1. Do you live in a private house, apartment, mobile home, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? NO YES
3. Is there a working smoke alarm on each floor in the house? NO YES
4. Does your child always use a car seat/seat belt when riding in a car? NO YES
5. Are there any smokers in the household? NO YES
6. Are there any problems with safety in the home? NO YES
Please note _____

Parent Signature: _____

Date: _____

Physician Signature: _____

Date: _____