

Patient's Name: _____

Date of Birth: _____

Birth History

Hospital of birth: _____

Was pregnancy normal? _____

Problems during labor: _____

Problems during delivery: _____

Was baby full term? _____

Type of delivery: Vaginal Caesarean Vacuum Extraction

Problems in the nursery: _____

Medical History

Any problems with:

Head: _____

Eyes: _____

Ears/Nose/Throat: _____

Chest/Heart/Lungs: _____

Stomach: _____

Kidneys: _____

Bladder: _____

Bones/Muscles/Joints: _____

Skin: _____ Blood: _____

Any significant family medical history:

Allergies: _____

Asthma: _____

Diabetes: _____

Heart disease: _____

Kidney disease: _____

Migraine: _____

Cancer: _____

Seizures: _____

Other: _____

Chronic Illness: _____

Medications: _____

Hospitalizations: _____

Surgeries: _____

Allergies: _____

Any special comments about your child: _____

