

- |  |                                      |                                       |
|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Newborn complications | <input type="checkbox"/> Injuries    | <input type="checkbox"/> Special Care |
| <input type="checkbox"/> Breathing Problems    | <input type="checkbox"/> Medications | _____                                 |
| <input type="checkbox"/> Seizures              | _____                                | _____                                 |
| <input type="checkbox"/> Jaundice              | _____                                | _____                                 |

**Family Medical History** (please check)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Lead poisoning               |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Cystic fibrosis     | <input type="checkbox"/> Learning disorder            |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Meningitis                   |
| <input type="checkbox"/> Attention problems         | <input type="checkbox"/> Eating disorders    | <input type="checkbox"/> Pain (chronic or unusual)    |
| <input type="checkbox"/> Bed wetting                | <input type="checkbox"/> Ear infections      | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Behavior problems          | <input type="checkbox"/> Eye problems        | <input type="checkbox"/> Prematurity                  |
| <input type="checkbox"/> Bleeding disorder (other)  | <input type="checkbox"/> Feeding problems    | <input type="checkbox"/> Shot (immunization) reaction |
| <input type="checkbox"/> Blood disorder (other)     | <input type="checkbox"/> Hearing problems    | <input type="checkbox"/> Sickle cell anemia           |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> _____                        |
| <input type="checkbox"/> Chronic lung disease (BPD) | <input type="checkbox"/> Injuries            | <input type="checkbox"/> _____                        |
| <input type="checkbox"/> Congenital disorders       | <input type="checkbox"/> Immune deficiency   | <input type="checkbox"/> _____                        |
| <input type="checkbox"/> Colic                      | <input type="checkbox"/> Kidney problems     | <input type="checkbox"/> _____                        |

**Surgeries**

\_\_\_\_\_

**Medications** (including prescription drugs, fluoride, vitamins and herbal products)

\_\_\_\_\_

**Developmental History**

- |  |  |
|--|--|
| <input type="checkbox"/> Rolled over _____     | <input type="checkbox"/> Walked holding on _____ |
| <input type="checkbox"/> Sat unassisted _____  | <input type="checkbox"/> Walked alone _____      |
| <input type="checkbox"/> Crawled _____         | <input type="checkbox"/> Spoke _____             |
| <input type="checkbox"/> Pulled to stand _____ | <input type="checkbox"/> Potty trained _____     |
| <input type="checkbox"/> Stood alone _____     | <input type="checkbox"/> _____                   |

**Activities**

- |                                   |                                     |
|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Dance    | <input type="checkbox"/> Gymnastics |
| <input type="checkbox"/> Swimming | <input type="checkbox"/> Soccer     |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Football | <input type="checkbox"/> Bicycling  |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      |

**Any special equipment or assisted devices?**  yes  no \_\_\_\_\_

**Any specific developmental concerns?**  yes  no \_\_\_\_\_

**Health Promotion & Safety**

- Are his/her immunizations up to date as far as you know?  yes  no  not sure
- Does he/she wear a safety belt in the car?  yes  no  sometimes
- Does he/she wear a bicycle helmet and/or other protective equipment?  yes  no  sometimes
- Are there any firearms in the home?  yes  no If so, are they loaded?  yes  no
- Is the gun unlocked?  yes  no Is the ammunition stored separately?  yes  no
- Does your home have a smoke detector?  yes  no Fire Extinguisher?  yes  no
- Carbon Monoxide detector?  yes  no

Have you discussed any of the following with your child? (if appropriate for your child's age)

- Abstinence, safe sex, condoms, HIV?  yes  no Puberty, menstruation (periods), etc.?  yes  no
- Drugs/alcohol/tobacco use?  yes  no

**Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_