# HISTORY
## BIRTH THROUGH FIVE YEARS

PATIENT NAME: ______________________________ DATE OF BIRTH: __________

PREGNANCY AND BIRTH: CIRCLE ONE:

1. Did you have any illnesses during your pregnancy ................................................Yes No
2. Did you carry him/her to term?............................................................................No Yes
3. Where was your baby born? ______________________________
4. How much did he/she weigh at birth? ________ lbs. ________ oz.
5. Did your baby have any trouble starting to breathe? ..............................................Yes No
6. Did your baby have any trouble in the hospital?......................................................Yes No
7. Did your baby go home from the hospital with you?................................................No Yes
8. How long did he/she stay in the hospital? _________ days.

FEEDING AND DIGESTION:

1. Did your baby have severe colic or any unusual feeding problems during the first three (3) months of life?.........................................................................................Yes No
2. If on vitamins, what kind and how much? __________________
3. If still on formula, which one do you use? _________________
4. Is your child's appetite usually good? .....................................................................No Yes
5. Do any foods bother him/her? ...............................................................................Yes No
6. Does he/she often have diarrhea or runny bowels? ................................................Yes No

BABY SHOTS, TESTS AND DEVELOPMENT:

1. Do you have your immunization records with you today?.........................................No Yes
2. Has your child had:
   - All 4 of his/her "DPT" shots ...............................................................................No Yes
   - All 3 doses of polio vaccine by mouth or shot?....................................................No Yes
   - MMR shot (Measles, Mumps, and Rubella)? .........................................................No Yes
   - Skin test for TB?...................................................................................................Yes No
3. Did your child sit alone before 7 months of age?.....................................................No Yes
4. Did your child walk alone before 15 months of age?................................................No Yes
5. Did your child say any words by 1½ years of age?...................................................No Yes
6. Is he/she as quick in learning as your other children?..............................................No Yes

ALLERGIES:

1. Has you child had:
   - Eczema or hives? ..................................................................................................Yes No
   - Wheezing or asthma? ............................................................................................Yes No
   - Allergies or reactions to any medicines/injections or foods?.................................Yes No
   - Does he/she have a constant cold, hay fever or sinus trouble? ...........................Yes No

FAMILY-SOCIAL HISTORY:

1. Are there any members of your child's immediate family (brothers, sisters, parents, grandparents, aunts or uncles) with a serious health problem (mental or physical)?...Yes No
   List each problem and who has it ______________________________
   ______________________________________________
2. How many people live in your home? _____ Children _____ Adults
3. With whom does the child live? (circle one)
   Both Parents Mother Father Legal Guardian Other
4. Does anyone help you take care of your child on regular basis?................................Yes No
5. Does anyone at home smoke? ................................................................................Yes No

**PLEASE COMPLETE THE BACK OF THIS PAGE**

INFECTIONS, ILLNESSES AND OTHER PROBLEMS:

Has your child:

1. Had more than 6 colds or throat infections each year? ............................................Yes No
2. Had more than 3 ear infections? ............................................................Yes No
3. Had any trouble hearing? ............................................................Yes No
4. Had his/her hearing tested? ............................................................No Yes
5. Had any trouble seeing? ............................................................Yes No
6. Had his/her eyes tested? ............................................................No Yes
7. Had any trouble with his/her teeth ............................................................Yes No
8. Seen a dentist recently? ............................................................No Yes
9. Had any trouble passing his/her urine? ............................................................Yes No
10. Ever had a convulsion, fit, or fainting spell? ............................................................Yes No
11. Circle any of the following that your child has had:
    10 day measles Chickenpox Mumps Whooping Cough
    Pneumonia Recent Bronchitis
12. Had other disease? ............................................................Yes No
    If yes, please list ____________________________________________
13. Had to stay in the hospital overnight? ............................................................Yes No
    If yes, Age __________ Hospital ______________________________
    Reason ____________________________________________

ACCIDENTS:

1. Has your child had any serious accidents? ............................................................Yes No
   Burns _____ Poisoning _____ Cuts needing a doctor _____ Broken bones _____
2. Does your child use a car seat or seat belt in the car? ............................................No Yes
3. Do you know how to prevent an infant from smothering or choking? ........................No Yes
4. Do you have firearms (loaded or unloaded) in your home? ......................................Yes No

BEHAVIOR AND DISCIPLINE:

1. Is he/she more difficult to raise than your other children? ........................................Yes No
2. What is the most effective way of disciplining your child? (circle one)
   Spanking Putting to Room Taking privileges away Other
3. Are you concerned about any of the following? (circle which ones)
   Bad Temper Thumb Sucking Won't pay attention Won't mind Nail biting
   Over-reactive Holds breath Speech problems Slow to learn Jealousy
   Can't toilet train Eats dirt or paint Sleep problems Very shy

**COMPLETED BY:** ____________________________________

**DATE:** ____________________________________________