

HISTORY
SIX THROUGH TWELVE 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. | | |

BABY SHOTS, TESTS AND DEVELOPMENT:

- | | | |
|--|-----|-----|
| 1. Do you have your immunization records with you today | No | Yes |
| 2. Has your child had: | | |
| All 5 of his/her "DPT" shots | No | Yes |
| All 4 doses of polio vaccines by mouth..... | 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 |

INFECTIONS, ILLNESSES AND OTHER PROBLEMS:

Has your child:

- | | | |
|---|-----|-----|
| 1. Had <u>more</u> than 6 colds or throat infections each year? | Yes | No |
| 2. Had <u>more</u> 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 |

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INFECTIONS, ILLNESSES AND OTHER PROBLEMS (continued):

6. Had his/her eyes tested?.....No Yes
7. Had any trouble with his/her teethYes 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 _____

BEHAVIOR AND DISCIPLINE:

1. What school does your child attend? _____ Grade _____
2. Does your child get along well in school?No Yes
3. Have you met with the teacher?No Yes
4. Is the teacher worried about any problemsYes No
5. Does your child get along well with other children?No Yes
6. What is the most effective way of disciplining your child? (circle one)
 Spanking Putting to Room Taking privileges away Other
7. 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: _____