Child's Name: ______________________________

MONMOUTH PEDIATRIC GROUP, PA

Date of Birth: ____________________

Birth History

Birth Weight ______________ Apgar ____________
At how many weeks gestation was the baby born? _____
Did mother have regular prenatal care? ☐ Yes ☐ No
Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain ______________________

During pregnancy, did mother:
Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medication ☐ Yes ☐ No
What ______________ When ________________

Was the delivery ☐ Vaginal? ☐ Caesarean?
If cesarean, why? ________________
Did your baby have any problems right after birth?
☐ Yes ☐ No Explain
____

Was initial feeding ☐ Breast? ☐ Bottle?
Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain
____

General

Do you consider your child to be in good health?	☐ Yes ☐ No	Explain ______________
Does your child have any serious illness or medical condition?	☐ Yes ☐ No	Explain ______________
Has your child had any serious injuries or accidents?	☐ Yes ☐ No	Explain ______________
Has your child had any surgery?	☐ Yes ☐ No	Explain ______________
Has your child ever been hospitalized since birth?	☐ Yes ☐ No	Explain ______________
Is your child taking any medications, including vitamins, minerals, or herbal supplements?	☐ Yes ☐ No	Explain ______________
Is your child allergic to any medications or drugs?	☐ Yes ☐ No	Explain ______________
Any allergies to foods or insect bites/stings?	☐ Yes ☐ No	Explain ______________

Development

Are you concerned about your child's physical development?	☐ Yes ☐ No	Explain ______________
Are you concerned about your child's mental/emotional development?	☐ Yes ☐ No	Explain ______________
Are you concerned about your child's attention span?	☐ Yes ☐ No	Explain ______________
Does your child have any problems speaking?	☐ Yes ☐ No	Explain ______________
If in school, how is your child doing in academic subjects?		Explain ______________

Has your child shown signs of puberty? ☐ Yes ☐ No If a girl, at what age was her first menstruation? _____

Past History

Does your child have, or has he/she ever had any of the following.

Chickenpox	☐ Yes ☐ No	Bladder or kidney infection	☐ Yes ☐ No
Frequent ear infections	☐ Yes ☐ No	Bed wetting (after 5 yrs old)	☐ Yes ☐ No
Problems with hearing	☐ Yes ☐ No	Any chronic skin problems	☐ Yes ☐ No
Nasal allergies	☐ Yes ☐ No	Frequent headaches	☐ Yes ☐ No
Problems with eyes / vision	☐ Yes ☐ No	Convulsions/seizures	☐ Yes ☐ No
Asthma, bronchiolitis, pneumonia	☐ Yes ☐ No	Neurological problem	☐ Yes ☐ No
Any heart problem or heart murmur	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Anemia or bleeding problem	☐ Yes ☐ No	Thyroid or other endocrine problem	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Any other significant problem	☐ Yes ☐ No
Frequent abdominal pain	☐ Yes ☐ No	Use of alcohol or drugs	☐ Yes ☐ No
Constipation requiring doctor visits	☐ Yes ☐ No	Use of tobacco products	☐ Yes ☐ No

Please elaborate on any yes responses:
____
____
____

Family History

Have any family members from mother's and father's side had the following:

Condition	Yes	No	Condition	Yes	No
Deafness	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Nasal allergies	☐ Yes	☐ No	Bed wetting (after 10 yrs old)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Convulsions/seizures	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Diabetes (before 50 years old)	☐ Yes	☐ No
Heart disease (before 50 years old)	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Unexplained or sudden death (before 50 yrs)	☐ Yes	☐ No	Drug abuse	☐ Yes	☐ No
High blood pressure (before 50 yrs old)	☐ Yes	☐ No	Mental illness	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Mental retardation	☐ Yes	☐ No
Anemia or bleeding problem	☐ Yes	☐ No	Immune problems, HIV, or AIDS	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No	Any other significant problems	☐ Yes	☐ No

Please elaborate on any yes responses:

____

____

Please let us know who referred your family to us so that we may thank them. ____________________

Who is completing this form: ____________________ Relationship to child: ____________________

Signature ______________________________ Date: ____________________