



Dear Parent,

By filling out this questionnaire a more complete record of your child is obtained. It also gives us permanent history which we can refer to later. It saves you time and ours. Answer any questions you can, don't worry about those you skip. We will discuss with you any items which either you or we believe should be explained more fully.

Patient's Last Name	First	Age	Date
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Pregnancy, Birth and Newborn History

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|---|-----|-------------|
| 1. Did you have an illness during your pregnancy? | Yes | No |
| 2. Did your baby come on time? | Yes | No |
| 3. How old were you when the baby was born? | | Years |
| 4. How many times have you been pregnant? | | _____ |
| 5. How many hours did the labor last? | | Hours |
| 6. How much did the baby weigh at birth? | | lbs. oz. |
| 7. Did your baby have any trouble starting to breath? | Yes | No |
| 8. Did the baby have any trouble while in the hospital? | Yes | No |

Family History

Please list the name and any medical conditions for each parent.

Parent name	Medical Condition, if any

Family History (continued)

Please list the names of the child's siblings and medical conditions if any.

Sibling name	Medical condition if any

Check any of the following conditions that the child's family member has had. Please provide the relationship of the family member to the child.

Medical Conditions	Relationship to child
Asthma	
Death – Unexpected, before the age of 50	
Diabetes	
Genetic Disorders	
Heart Disease	
High Blood Pressure	
Mental Illness	
Seasonal Allergies	
Seizures	
School Problems	
Miscellaneous	