CHILDREN'S HEALTH RECORD

ABOUT THE CHILD

Name_____
Birthdate_____ Age_____
Gender □M □F Height_____ Weight_____
Address_____
City/State/Zip_____
Home Phone_____
Parents' Name(s)_____

MOTHER'S PREGANCY & LABOR

During pregnancy, did the mother:
……take any medication? ○ No ○ Yes
Explain_____
……smoke or consume alcohol? ○ No ○ Yes
……experience any illness? ○ No ○ Yes
Explain_____
Approximately how long did labor last? _____hours

Was labor chemically induced? ○ No ○ Yes
Was labor doctor assisted? ○ No ○ Yes
Was a C-Section performed? ○ No ○ Yes
Were forceps or vacuum extraction used? ○ No ○ Yes
Did the delivery doctor pull or twist the baby during delivery ○ No ○ Yes
Was the delivery premature? ○ No ○ Yes
If "yes" at____ month and _____weight

Check any of the following if the child experienced it immediately after birth?
○ Jaundice ○ Feeding Problems
○ Respiratory Problems ○ Displaced or Broken joints
○ Other Conditions
Explain_____
_____
_____

REASON FOR THIS VISIT

Describe the purpose of this visit,
_____
_____
Is the purpose of this appointment related to
○ Sports ○ Auto ○ Fall
○ Home injury ○ Chronic discomfort
○ Other
Explain_____
When did this condition begin? _____
_____
Has this condition
○ Gotten worse ○ Stayed constant
○ Comes and goes
Does this condition interfere with
○ Sleep ○ daily routine ○ other activities
Explain_____
Has the condition occurred before?
○ Yes ○ No
Have you seen other doctors for this condition
○ Yes ○ No
Dr.'s Name _____
Type of Treatment_____
Results_____

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis

○ Vision Problems
○ Headaches
○ Sleeping Disorders
○ Irritability
○ Skin Problems
○ Allergies
Problems
○ Breathing Problems
○ Asthma
○ Hyperactivity
○ Constipation
○ Bed Wetting
○ Pink Eye
○ Ear Problems
○ Tubes in ears
○ Attention Prob.
○ Frequent Colds
○ Colic
○ Digestive Prob.
○ Other_____
_____
_____