YOUR CHILD'S HEALTH HISTORY (C& C Medical Associates, PLLC)

Dear Parents:

By filling out this questionnaire, a more complete record of your child is obtained, and it gives us a permanent history to which we can refer later. Answer all the questions you can, but don't worry about those you skip.

Child's Name _____ Child's DOB _____ Today's Date _____

PREGNANCY, BIRTH AND NEWBORN

1. Did the mother have any illnesses during her pregnancy? Yes No
   If so, did she require medication? Yes No
   Name of medication: _____
2. How old was the mother when the baby was born? ____ Yrs Old
3. How many times has the mother been pregnant, including this one? ____
4. Did the mother use any alcohol, tobacco or drugs during the pregnancy? Yes No
5. Did the baby come significantly before or after the due date? Yes No
6. What was the birth weight? ____ lbs. ____ ozs.
7. Did the baby have any trouble starting to breathe? Yes No
8. Did the baby have any trouble while in the hospital? Yes No

MEDICAL HISTORY

1. Was there severe colic or any unusual feeding problems in the first three months? Yes No
2. Are there any problems with your child's appetite? Yes No
3. Has there been a problem with excess or poor weight gain? Yes No
4. Are there any feeding issues? Yes No
5. Does he/she often have diarrhea or constipation? Yes No
6. Does he/she take any medicines regularly? Yes No
7. Has he/she had skin problems? Yes No
8. Has he/she ever had wheezing or asthma? Yes No
9. Is there any history of heart problems? Yes No
10. Does he/she tend to have a chronic stuffy nose or "constant cold"? Yes No
11. Has your child had excessive ear trouble? Yes No
12. Does he/she have any hearing problems? Yes No
13. Does he/she have any trouble passing urine? Yes No
14. Has he/she ever had a seizure or loss of consciousness? Yes No
16. Has he/she had any trouble with his/her eyes? Yes No
16. Are there any problems with his/her teeth? Yes No
17. Is there anything wrong with the way he/she walks? Yes No
18. Circle any of the following that your child has had:

Broken Bones	Serious injuries
Whooping cough (pertussis)	Chickenpox
Pneumonia	

19. Current Medications _____
_____

20. Any allergies or reactions to any medicines or injections? Yes No

21. Any hospitalizations? (list) _____
_____

22. Any other major illnesses or chronic problems? (list) _____

_____

_____

23. Any surgeries? (list) _____

24. Are immunizations up to date? (If you are a new patient, please provide records) Yes No

DEVELOPMENTAL HISTORY

1. At what age did he/she sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 18 months old? Yes No
4. If you did not know your child's age, how old would you guess him/her to be from the way he/she acts? _____
5. Is he/she doing well in school? Yes No
6. Does he/she get along well in school? Yes No
7. Do you generally enjoy your child and find him/her a pleasure? Yes No
8. Circle any of the following problems which your child has:

Wets bed	Bowel problems	Speech problems
Won't toilet train	Nightmares	Destructive
Wetting during day	Breath-holding	Mean to animals
Nervous habits of any kind	Temper tantrums	School problems

FAMILY HISTORY

1. List first name, age, general health and years of education of child's parents:
   Mother _____
   Father _____

2. Parents are (please circle): MARRIED DIVORCED NEVER MARRIED OTHER

3. List ages, sex, and general health of child's brothers and sisters:

_____

_____

_____

4. Please list all living in the child's current household (if different from above):_____

_____

5. Have any of your children died? Yes No
6. Are there any issues of substance abuse or violence in the household or family? Yes No
6. Circle any of the following diseases that this child's natural relatives have had: mother (M), father (P), Brother (B), sisters (S), grandparents (MGM/MGF/PGM/PGF), aunts (A), uncles (U), first cousins (C)

Mental retardation _____	Mental illness _____	Cerebral Palsy _____
Deformities, birth defects _____	Seizures, Convulsions _____	Ulcers _____
Diabetes _____	Deafness _____	Urinary tract infections _____
Early death _____	Inherited Diseases _____	High blood pressure _____
Heart disease as a child _____	Allergy, such as hay fever, asthma _____	High Cholesterol _____

7. What doctors have taken care of your child in the past? _____

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