PARK WEST
FAMILY MEDICINE

CHILD HISTORY RECORD

To be filled out by parent or guardian

Today's date _____

Name _____ Age _____ Birth date_____

PREGNANCY AND BIRTH

Age of mother at baby's birth _____ Birth weight _____ Birth length _____

Infant's gestational age: ☐ Full-term ☐ Pre-term If pre-term, number of weeks: _____

Mother's blood type _____ Infant's blood type (if known) _____

Apgar scores (if known): _____ Mother Group B Strep status: _____

Type of delivery: ☐ Vaginal ☐ C-section If C-section, reason: _____

Initial feeding of baby: ☐ Breast ☐ Bottle

Obstetrician's name _____ City, State _____

Did mother use cigarettes, recreational drugs or medication during this pregnancy? ☐ Yes ☐ No

If yes, explain: _____

Were there any medical problems during pregnancy? ☐ Yes ☐ No
(i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor)

If yes, explain: _____

Were there any problems during labor? ☐ Yes ☐ No

If yes, explain: _____

Were there any problems during the nursery stay? ☐ Yes ☐ No
(i.e., jaundice, prematurity, feeding difficulties, breathing problems, infections)

If yes, explain: _____

Form continues on reverse side ...

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CHILD HISTORY RECORD (Cont'd)

HOSPITALIZATIONS OR SERIOUS/UNUSUAL ILLNESSES

Identify any serious and/or unusual illnesses that your child has experienced and the corresponding date(s):

Date	Serious/unusual illness	Hospital/Physician's name	City, State

ALLERGIES

List allergies, including any allergic reactions to drugs _____

_____

FAMILY HISTORY

Check if the child or child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems:

	Child	*Family*		*Child*	*Family*
Frequent ear infections	☐	☐	Kidney / bladder problems or infections	☐	☐
Frequent colds / sore throats	☐	☐	Seizures / convulsions	☐	☐
Croup	☐	☐	Early heart disease (age 50 or younger)	☐	☐
Cystic fibrosis	☐	☐	High blood pressure	☐	☐
Wheezing / asthma	☐	☐	High cholesterol	☐	☐
Pneumonia	☐	☐	Lung disease / tuberculosis	☐	☐
Eye problems	☐	☐	Sexually transmitted diseases	☐	☐
Dental problems	☐	☐	Alcohol / drug abuse	☐	☐
Hearing problems	☐	☐	Emotional disorders / suicide attempts	☐	☐
Hay fever	☐	☐	Cancer	☐	☐
Eczema / skin problems	☐	☐	Unexplained childhood deaths	☐	☐
Anemia / blood problems	☐	☐	Other illnesses:		
Diabetes	☐	☐	_____		

CHILD HISTORY RECORD (Cont'd)

FAMILY HISTORY (Cont'd)

General health of imediate family members:

Mother's first name	Date of birth	Healthy	Problems (explain)
_____	_____	☐	☐ _____
Father's first name	**Date of birth**	**Healthy**	**Problems (explain)**
_____	_____	☐	☐ _____
Sibling's first names	**Date of birth**	**Healthy**	**Problems (explain)**
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____
_____	_____	☐	☐ _____

Have any of the child's siblings died? ☐ No ☐ Yes (explain) _____

HEALTH AND SAFETY ISSUES

Are there any guns in the child's house?	☐ Yes	☐ No
Are the child's teeth brushed daily?	☐ Yes	☐ No
Does the child use a car seat or seat belt all the time?	☐ Yes	☐ No
Are there smoke detectors in the child's home?	☐ Yes	☐ No
Is the hot water temperature less than 125°?	☐ Yes	☐ No
Do you have rules/limits for television viewing?	☐ Yes	☐ No
Are medicines and potential poisons out of reach?	☐ Yes	☐ No
Do you have syrup of ipecac?	☐ Yes	☐ No
Do you know child resuscitation or choking management?	☐ Yes	☐ No