History Form to Be Filled Out By Mother

SOUTHERN PLAINS MEDICAL CENTER

NAME____
Patient Likes To Be Called _____________________________
Date of Birth ___________________________________
Mother's Name _____________________________________

A. PREGNANCY AND BIRTH:

1. Did you have an illness during your pregnancy?…….. No Yes
2. Did the baby come on time?…………………………...No Yes
3. What was the birth weight? ……………………………___________
4. Did your baby have any trouble starting to breath?……No Yes
5. Did the baby have any trouble while in the hospital?….No Yes

B. FEEDING AND DIGESTION:

1. Was there severe colic or any unusual feeding problems the first 3 months? …………………….Yes No
2. Is your child's appetite usually good? ………………… Yes No
3. Is it good now? ………………………………………… Yes No
4. Do any foods disagree with him/her?……………… … No Yes
5. Does he/she often have diarrhea? ……………………… No Yes
6. Has constipation ever been much of a problem? ……… .No Yes
7. If on vitamins, what kind and how much? ……………..________
8. If still on formula, what one do you use?………………________

C. FAMILY HISTORY:

1. Circle any of the following diseases that this child's parents, Grandparents, aunts, uncles, brothers, or sisters have had:

Seizures diabetes allergy
Inherited or family disease tuberculosis
Nervous breakdown asthma cancer

2. Are the child's parents both in good health? …………. Yes No
3. list ages, sex, and general health of brothers and sisters:
____
____
____

Have any of your children died? Yes No

D. INFECTIONS, ILLNESSES, MISCELLANEOUS PROBLESM AND DEVELOPMENT:

Has your child

1. Had as many as three attacks of ear trouble? ……No Yes
2. Had more than three colds or throat infections with a fever a year? No Yes
3. Had any trouble with urination? ……………………………………..No Yes
4. Ever had a convulsion? ………………………………………………No Yes
5. Had any trouble with hearing? ………………………………………No Yes
6. Had any trouble vision? …………………………………………….. No Yes
7. At what age did your child
   Sit alone ……………………………………………………………________
   Walk alone …………………………………………………………________

8. Did your child say any words by the age of 1 ½ years? …… NO YES
9. Does your child have any trouble sleeping?……………….. .NO YES
10. Does your child have dental problems? ………………….. NO YES
11. Circle any of the following that your child has had:

"red" measles mumps chickenpox roseola whooping cough
German or "3-day" measles pneumoniaserious accidents
broken bones removal of tonsils or adenoids
Other operations ____
Other diseases – what? ____________________________________
Hospitalizations – for what? _______________________________

E. ALLERGIES:

Has your child ever had:

1. Eczema or hives ………… ………………….No Yes
2. Wheezing or asthma? …………………………………….No Yes
3. Allergies or reactions to any medicines or injections?……No Yes
4. Does he/she tend to have a stuffy nose or constant cold?…No Yes

F. BEHAVIOR

Does your child

1. Get along well in school? …………………………………Yes No
2. Get along well with other children? …………..Yes No
3. Have any of the following problems (circle)

nail biting irritable speech problems
thumbsucking wets bed breath holding
nightmares won't mind jealousy
bad temper can't toilet train

G. TESTS AND IMMUNIZATIONS

1. HIB Vaccination? ………………………………Yes No
   give date ………………………………_________
2. "DTP" OR Diphtheria, tetanus, and whooping cough immunizations? ______________
   give date of last booster…..__________________
3. All three doses of polio vaccine by mouth? …….Yes No
4. MMR Vaccine? …………………………………Yes No
   give date ……………………………____________
5. Skin test for tuberculosis? ………………………Yes No
   give date of last test ………………..______________
6. Hearing tested? ………………………………….Yes No
7. Vision tested? …………………………………..Yes No
8. When did child last see a dentist? …………______________