

If No, please explain:

Did the baby pass the hearing screen completed at the hospital? _____ No _____ Yes

Was the baby born at term? _____ No _____ Yes If No, how many weeks? _____

Did baby have metabolic screening done? (PKU testing) _____ No _____ Yes

Any abnormalities found? _____ No _____ Yes If Yes, please explain _____

Did mother have any illness or problem with pregnancy? No _____ Yes _____

If Yes, please explain:

During pregnancy did mother smoke: _____ No _____ Yes

Use drugs or medication _____ No _____ Yes If yes, what _____ when _____

Drink Alcohol _____ No _____ Yes

CHILDS PAST MEDICAL HISTORY

Has your child had any surgery? ___ No ___ Yes Explain: _____

Has your child ever been hospitalized? ___ No ___ Yes Explain _____

Is your child allergic to any medications? ___ No ___ Yes Explain _____

Is your child allergic to any foods? ___ No ___ Yes Explain _____

Has your child been seen by a specialist? ___ No ___ Yes When _____ Who _____

Does your child have or has he/she ever had any of the following:

Frequent ear infection _____ No _____ Yes Explain _____

Problems with ears or hearing _____ No _____ Yes Explain _____

Asthma /wheezing _____ No _____ Yes Explain _____

Bronchitis _____ No _____ Yes Explain _____

Pneumonia _____ No _____ Yes Explain _____

Nasal allergies _____ No _____ Yes Explain _____

Any heart problem or heart murmur _____ No _____ Yes Explain _____

Anemia _____ No _____ Yes Explain _____

Bleeding disorder _____ No _____ Yes Explain _____

Blood transfusion _____ No _____ Yes Explain _____

Frequent abdominal pain _____ No _____ Yes Explain _____

Constipation requiring doctors visits ____ No ____ Yes Explain _____

Bladder or kidney infection ____ No ____ Yes Explain _____

Bed-wetting (after 5 years of age) ____ No ____ Yes Explain _____

Any chronic or recurrent skin problems ____ No ____ Yes Explain _____
(Acne, eczema, etc)

Seizures ____ No ____ Yes Explain _____

Thyroid or other endocrine problems ____ No ____ Yes Explain _____

Diabetes ____ No ____ Yes Explain _____

Use of alcohol or drugs ____ No ____ Yes Explain _____

Celiac disease ____ No ____ Yes Explain _____

Concussion/Head injury ____ No ____ Yes Explain _____

Any other significant problems ____ No ____ Yes Explain _____

FOR GIRLS ONLY

Has she started a menstrual cycle? ____ No ____ Yes Explain _____

Are there problems with her periods? ____ No ____ Yes Explain _____

CURRENT MEDICATION

_____	_____
Name of Medication	Dosage

_____	_____
Name of Medication	Dosage

_____	_____
Name of Medication	Dosage

ACADEMIC HISTORY

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Does your child have an IEP? _____

DEVELOPMENTAL HISTORY

Do you have any concerns about your child's development? ____ No ____ Yes Explain _____

Has you child had speech therapy? ____ No ____ Yes Explain _____

Has your child has physical therapy? ____ No ____ Yes Explain _____

Has your child had occupational therapy? ____ No ____ Yes Explain _____

FAMILY HISTORY

Have any family members had the following:

Deafness ___ No ___ Yes Who _____ Comments _____

Allergies ___ No ___ Yes Who _____ Comments _____

Asthma ___ No ___ Yes Who _____ Comments _____

Tuberculosis ___ No ___ Yes Who _____ Comments _____

Heart Disease ___ No ___ Yes Who _____ Comments _____

High blood pressure ___ No ___ Yes Who _____ Comments _____

High Cholesterol ___ No ___ Yes Who _____ Comments _____

Anemia ___ No ___ Yes Who _____ Comments _____

Bleeding Disorder ___ No ___ Yes Who _____ Comments _____

Liver Disease ___ No ___ Yes Who _____ Comments _____

Kidney Disease ___ No ___ Yes Who _____ Comments _____

Diabetes ___ No ___ Yes Who _____ Comments _____

Bed-wetting ___ No ___ Yes Who _____ Comments _____

Epilepsy or convulsion ___ No ___ Yes Who _____ Comments _____

Alcohol abuse ___ No ___ Yes Who _____ Comments _____

Drug abuse ___ No ___ Yes Who _____ Comments _____

Mental illness ___ No ___ Yes Who _____ Comments _____

Mental retardation ___ No ___ Yes Who _____ Comments _____

Immune problems ___ No ___ Yes Who _____ Comments _____

Celiac disease ___ No ___ Yes Who _____ Comments _____

Prolonged QT Syndrome ___ No ___ Yes Who _____ Comments _____

Has anyone in your family died suddenly under the age 50 ___ No ___ Yes Who _____

Autism ___ No ___ Yes Who _____ Comments _____

HIV/AIDS ___ No ___ Yes Who _____ Comments _____

SOCIAL HISTORY

Does any of your family member or caregiver smoke? ___ No ___ Yes

Is your child in daycare? ___ No ___ Yes

Are there any guns in the home? ___ No ___ Yes

Are there any pets in the home? ___ No ___ Yes If yes, type: _____