

PEDIATRIC FAMILY AND PERSONAL HEALTH HISTORY

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name _____ Gender M F Today's Date _____

Age _____ Birth date _____ Race _____

Father's Name _____ Father's Birth Date _____

Mother's Name _____ Mother's Birth Date _____

INFANT HEALTH HISTORY

Birth Weight _____ lbs. _____ oz. Gestation Age _____

Age when discharged from hospital _____ days

Was your baby
 Jaundiced Yes No Age _____ How Long _____
 Breast Fed Yes No _____ months
 Formula Fed Yes No _____ months

Did your baby:
 See a doctor for well baby care Yes No
 See a doctor for illness/problem Yes No

Describe _____

Primary drinking water supply: Well City/Municipal Bottled

Area Water Fluoride Level: _____

Vitamin/Fluoride Supplement Fluoride-Only Supplement

OPERATIONS / HOSPITALIZATIONS	Date and Outcome

CHRONIC PROBLEMS / ILLNESSES	Onset and Status

FAMILY HEALTH HISTORY

Relationship:	Age, if Living	Age at Death/Cause of Death
Father	_____	_____
Mother	_____	_____
Siblings (<i>circle one</i>)	_____	_____
male / female	_____	_____
male / female	_____	_____
male / female	_____	_____

FAMILY MEDICAL PROBLEMS

Please identify any medical problems blood relatives have or ever have had. Provide details for all "Yes" answers in the space provided below.

Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member (s)
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genetic Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone/Joint Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye or Ear Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia/Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease/Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental disease/Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Provide details of medical problems listed above:

Doctors Use Only - Summary

ALLERGIES
