Today's Date:_____

Child's Name:_____ M F Birthdate:_____
Last First

Parent/Mother:_____
Mother's birthdate:_____
Address:_____
Profession:_____
Employer:_____
Phones, Home:_____ Work:_____
Email:_____
Health Insurance:_____
Policy Number:_____
Subscriber:_____
Social Security # of Subscriber:_____
Referred By:_____

Parent/Father:_____
Address:_____
Profession:_____
Employer:_____
Phones, Home:_____ Work:_____
Email:_____
Parents are:
Single Married Separated Divorced Widowed

Delivery Hospital:_____
Obstetrician:_____
Due date:_____

CHILD'S BIRTH HISTORY

During your pregnancy with this child, did you:

Have high blood pressure?	Yes	No
Have diabetes or sugar in your urine?	Yes	No
Take any prescription medicine?	Yes	No
Smoke cigarettes?	Yes	No
Have drug or alcohol dependency	Yes	No

If yes, please explain:_____
Other Conditions:_____
How long was your pregnancy?_____

Was more than one baby born?	Yes	No
Did you have a difficult delivery?	Yes	No
Was it a cesarean section?	Yes	No
Was anything wrong with the baby?	Yes	No

If YES, what?_____

MATERNAL AND FAMILY HISTORY

How many children have you (mother) had? _____
Which one is this child?_____
Ages of all child's siblings?_____
Have you had any premature births?_____
Have you had any miscarriages?_____
Mother's age now_____ Mother's height_____
Father's age now_____ Father's height_____
Number of people living in child's home_____
Who spends most time caring for child?_____

FAMILY ILLNESS RECORD

PLEASE MARK AN "X" IN BOXES IF YOUR CHILD'S BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING:	FATHER	MOTHER	FATHER'S SIDE	MOTHER'S SIDE	SISTERS	BROTHERS
ALCOHOL OR DRUG DEP.						
ASTHMA						
BIRTH DEFECTS						
BLOOD DISEASE						
CANCER						
EARLY HEART ATTACK						
EYE OR EAR DISORDER						
JUVENILE DIABETES						
KIDNEY DISEASE						
MENTAL RETARDATION						
PSYCHIATRIC PROBLEM						
SERIOUS ALLERGIES						
THYROID DISEASE						