# CHILDREN'S CLINIC INITIAL HISTORY

Name _____ DOB _____ Date _____

Address _____ Phone _____

Person Providing initial history _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

## Birth and Development History

Problems with pregnancy? _____

Premature? _____

Birth weight _____

Birth length _____

Delivery problems? _____

NICU? _____

At what age did the child:

Smile _____ Roll Over _____

Sit alone _____ Walk _____

Talk _____ Toilet train _____

List siblings:

_____

_____

_____

_____

## Family History

1. Child 2. Mother 3. Father 4. Siblings 5. Maternal grandmother 6. Paternal grandmother
7. Maternal grandfather 8. Paternal grandfather 9. Maternal aunt/uncle 10. Paternal aunt/uncle

| | | |
|---|---|---|
| Allergies _____ | Asthma _____ | Kidney Disease _____ |
| Stroke _____ | Anemia/bleeding _____ | Cancer _____ |
| Seizures _____ | Diabetes _____ | Alcohol/Drug use _____ |
| Hepatitis _____ | TB _____ | Genetic Disorder _____ |
| Mental/Nervous _____ | Heart Problems _____ | High Blood Pressure _____ |
| Sickle cell _____ | HIV _____ | Birth Defects _____ |

Do parents smoke? _____

## Past Medical History

Has your child had:

1. Any serious illness? _____
2. Ever been hospitalized? ☐Yes ☐No When? _____
   Why? _____
3. Ever had any surgery? ☐Yes ☐No When and type? _____
4. Ever had a major injury? ☐Yes ☐No When and type? _____
5. Is child taking any medication? ☐Yes ☐No _____
6. Does child have any allergies? ☐Yes ☐No _____
7. Has child ever had:

| | | | |
|---|---|---|---|
| Measles | ☐Yes ☐No | Meningitis | ☐Yes ☐No |
| Mumps | ☐Yes ☐No | Vision/Hearing problems | ☐Yes ☐No |
| Chicken pox | ☐Yes ☐No | Devices/Equipment | ☐Yes ☐No |