CHILD'S HISTORY

CHILD'S NAME: _____
Last Name First Name Middle Initial

DEVELOPMENT: _____

Please try to estimate the age at which your child could do the following things:

Sat alone: _____ Walked Alone _____ Spoke first word _____ Several words _____

SCHOOL PERFORMANCE:

Who lives at home? _____ Does mother work? _____

Preschool or Daycare? _____ Name preschool, childcare: _____

Who cares for child/children while parent(s) is/are at work? _____

REVIEW OF SYSTEMS:

Has your child had any of the problems listed in the family history (separate page)? _____ Yes _____ No

Has she/he had frequent problems with:

_____ Head: Headaches, dizziness, injury, other _____

_____ Eyes: Vision problems, infection, pain, other _____

_____ Ears: Hearing problems infections, pain, other _____

_____ Nose: Frequent stuffiness, easy bleeding, other _____

_____ Mouth: Tooth decay, poor bite, other _____

_____ Throat: Frequent sore throat, trouble with swallowing, other _____

_____ Neck: Stiffness, swelling, swollen glands, other _____

_____ Chest: Deformity, pneumonia, cough, asthma, other _____

_____ Heart: Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other _____

_____

_____ Abdomen: Vomiting, frequent pain, diarrhea, constipation, other _____

_____ Urinary: Pain on voiding , voiding frequently, bed wetting, other _____

_____ Skin: Rash, infection, other _____

_____ Neurological: Development problems, seizures, meningitis, other _____

_____ Endocrine: Weight gain or loss, intolerance to heat/cold, thirst, hair changes such as thinning or falling out, other _____

_____ Arms & Legs: Deformity, abnormal walking, joint pain, joint swelling, other _____

_____ Hematological: Anemia, abnormal bleeding, other: _____

If yes to any of the above, please explain: _____

_____

_____

Are there specific problems you wish to discuss today? If so, please explain: _____

_____

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