

Prenatal History

Type of Birth Attendant: <input type="checkbox"/> OB/GYN <input type="checkbox"/> CNM <input type="checkbox"/> Lay Midwife	Name of attendant:
Location of Birth: <input type="checkbox"/> Home <input type="checkbox"/> Birthing Center <input type="checkbox"/> Hospital	
Complications during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:
Ultrasounds during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number:
Medications during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:
Cigarette/alcohol use during pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth intervention: <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Caesarian: Planned or Emergency?	
Complication during delivery: <input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:
Genetic disorders or disabilities: <input type="checkbox"/> Yes <input type="checkbox"/> No	Please describe:
Birth weight:	Birth length:
APGAR scores _____, _____	

Feeding History

Breast fed: <input type="checkbox"/> Yes <input type="checkbox"/> No	How long?	Formula fed: <input type="checkbox"/> Yes <input type="checkbox"/> No	How long?
Formula type:	Introduced to solids at: _____ months	Cow's milk at: _____ months	
Food/juice allergies or intolerances: <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:			

Developmental History

Number of hours sleeping per night:	Quality of sleep: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
At what age was your child able to: Respond to sound?	Hold head up?
Respond to visual stimuli?	Sit up?
Stand alone?	Cross crawl?
Walk alone?	
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Does this apply to your child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is/has your child been involved in any high impact or contact type sports? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:	
Has your child ever been involved in a car accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Has your child been seen on an emergency basis? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason and date:	
Other traumas not described above? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	
Prior surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No Type and Date:	Menarche: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:

Childhood Diseases

Chicken pox: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:	Mumps: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Rubella: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:	Whooping cough: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:
Rubeola: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No Age:

Authorization for Care of Minor

We are here to serve you and encourage you to ask questions.

Your participation is vital and will help determine your results.

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed

Witnessed

_____/_____/_____
Date