

Name: \_\_\_\_\_

Longneck Family Practice – Child Health

Date : \_\_\_\_\_

**Birth History**

1. Gestational Age (How on time was your child)  
\_\_\_\_\_ weeks

2. Birth Weight: \_\_\_\_\_

3. Birth Length: \_\_\_\_\_

4. Any complications during pregnancy?  
\_\_\_\_\_

5. Did mom drink alcohol during pregnancy Y N

6. Did mom smoke during pregnancy Y N

7. Was the delivery:  
Spontaneous Vaginal Delivery  
Induced Vaginal Delivery  
C-Section  
If induced or C-Section then why? \_\_\_\_\_

8. Delivery Complications? \_\_\_\_\_

9. Nursery Complications? \_\_\_\_\_

10. Mom's Name: \_\_\_\_\_  
Phone # \_\_\_\_\_

11. Dad's Name: \_\_\_\_\_  
Phone # \_\_\_\_\_

12. Age and Gender of Siblings:  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History – Has your child had?**

Chicken Pox Disease	Y	N
Vaccine	Y	N
Asthma	Y	N
Allergies	Y	N
Dry Skin (Eczema)	Y	N
Ear Infections (>2/year)	Y	N
Feeding Problems	Y	N

ADD/ADHD	Y	N
Problems with BM (Stool)	Y	N
Problems with urination (pee)	Y	N
Growth/Language Delay	Y	N

List additional Medical Problems:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Surgeries: \_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Does your child Smoke Y N

Other family members who smoke: \_\_\_\_\_  
\_\_\_\_\_

Pets? \_\_\_\_\_

Well Water?	Y	N
Day Care?	Y	N
Home Mom/Dad	Y	N

**Family History of?**

\_\_Asthma \_\_Juvenile Diabetes \_\_Seizures  
 \_\_Allergies \_\_Congenital Heart Dz \_\_Sickle Cell  
 \_\_Migraines \_\_Childhood Cancers \_\_Other (list below)

Relatives	Age if living	Age and year of death	Current Illness	Cause of Death
Mother				
Father				

Additional Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_