

Name: _____ Date: _____

HEALTH INFORMATION BACKGROUND (Child: 2 Years or Younger)

Please take a few minutes to complete the following, describing your child's **usual** condition. His/her current problem will be discussed in depth with your doctor.

Did child's mother have any complications or illnesses during pregnancy? _____ If yes, explain _____

Medications taken during pregnancy _____

Was child born at term (40 weeks)? _____ If not, how early/late? _____

(Circle One) Delivery Vaginal or Caesarean Section? Please explain any difficulties during labor and or delivery: _____

Child's birth weight _____ length _____ single delivery? _____ Did child leave hospital with mother? _____

Does the child have? (check if yes):

____ Feeding Problems ____ Birth Defects
____ Breathing Problems ____ Jaundice
____ Metabolic Problems ____ Liver Problems
____ Cystic Fibrosis ____ Thyroid Disease
____ Bowel or Bladder Problems

Has your child ever had? (if yes give the date)

____ Ear Infections ____ Pneumonia
____ Chicken Pox ____ Mumps
____ Tuberculosis ____ Measles
____ Seizures ____ Croup
____ Anemia ____ Other explain

Does child breastfeed? _____ How often and for how long? _____

Type of formula? _____ How often and how much? _____

Does child take vitamins? _____

Age (approximate) when child:

Lifted head while laying on stomach _____

Was able to roll over _____

Could sit up without help _____

Spoke first word _____

Spoke in a sentence _____

Started solid foods _____

Is child up to date for age with immunizations? _____ If no, which were missed? _____

Any reactions to previous immunizations? _____

Any Hospitalizations? _____

Surgeries? _____

Allergies? _____

Medications? _____

Do any illnesses or conditions run in the child's family? _____ If yes, explain _____

Other Concerns or problems we should know about: _____