HEALTH HISTORY

BIRTH

Hospital_____ Obstetrician_____

Type of Delivery_____ Complications_____

Birth Weight_____ Birth Length_____ Discharge Weight_____

Blood Group_____ Hearing Test: Passed_____ Failed_____ Not Done_____

Type of Feeding_____ Hep B Vaccination: Done_____ Not Done_____

Did baby have any problems at or immediately after birth?_____

FAMILY HISTORY

Name of Sibling(s)_____ Date of Birth _____

_____ _____

_____ _____

_____ _____

Do relatives have any of the following? *(Indicate relationship)*

Anemia_____ Diabetes_____

Asthma_____ Allergies_____

Heart Disease_____ High Blood Pressure_____

Convulsions/Seizures_____ Heart Disease_____

Birth Defects_____ Kidney Disease_____

Vision, Speech or Hearing Problems_____

Other_____

CHILD'S MEDICAL HISTORY

Previous Doctor_____ Address_____

Vaccines ☐Up to Date ☐Unvaccinated ☐Amended Schedule *(indicate vaccines below)*

_____

Childhood Illnesses _____

_____

Any Operations_____

Allergies_____ Latex Allergy_____

Behavioral difficulties_____

_____

Other_____

Whom may we thank for referring you to Petite Pediatrics? _____