Cape Cod Pediatrics, LLP
Personal Health History Form

Patient Name ___________________________
Date of Birth ___________________________
Today's Date___________________________

Please answer the following questions regarding your child's birth history:

Birth Hospital____________________________ Mom's age at birth__________ Gestational age at birth_________weeks

Birth weight___________________ Discharge weight______________ *Please circle one:* Vaginal birth / C-Section

Please circle Yes or No to answer the following questions about your child's birth and first days of life

Pregnancy Complications	**Y / N**	Vacuum-Assisted Birth	**Y / N**	NICU admission	**Y / N**
Preterm Labor	**Y / N**	Scalp bruise	**Y / N**	Neonatal Abstinence Syndrome	**Y / N**
Premature Rupture of Membranes	**Y / N**	Meconium	**Y / N**	Jaundice	**Y / N**
Fetal Distress	**Y / N**	Intubation/ Breathing Problems	**Y / N**	Passed Hearing Test	**Y / N**
Maternal or Child Infection	**Y / N**	Clavicle Fracture	**Y / N**	Received Hep B Vaccine	**Y / N**

Other: *Please explain any "Yes" answers in the space provided:*

Please circle Yes or No to indicate whether or not your child currently has or has previously had the following conditions:

ADD/ ADHD	**Y / N**	Ear/ Hearing Problems	**Y / N**
Allergies	**Y / N**	Eczema/ Hives / Skin Problems	**Y / N**
Anemia	**Y / N**	GERD/Reflux	**Y / N**
Anxiety Disorders	**Y / N**	Headaches/Migraines	**Y / N**
Arthritis	**Y / N**	Heart Disease/Heart Problems	**Y / N**
Asthma	**Y / N**	High Blood Pressure	**Y / N**
Bedwetting	**Y / N**	High Cholesterol	**Y / N**
Bladder or Kidney Problems	**Y / N**	Hospital Admission (other than birth)	**Y / N**
Blood Diseases	**Y / N**	Kidney Disease/ Kidney Stones	**Y / N**
Cancer	**Y / N**	Liver Disease	**Y / N**
Chicken Pox	**Y / N**	Muscle/ Joint/ Bone Problems	**Y / N**
Concussion/Head Injury	**Y / N**	Seizures/ Epilepsy	**Y / N**
Congenital Anomalies	**Y / N**	Serious Illness or Injuries	**Y / N**
Constipation	**Y / N**	Surgeries	**Y / N**
Depression	**Y / N**	Thyroid Problems	**Y / N**
Developmental/ Behavioral Disorders	**Y / N**	Tuberculosis	**Y / N**
Diabetes/ Endocrine Problems	**Y / N**	Vision/ Eye Problems	**Y / N**

Other: *Please explain any "Yes" answers in the space provided:*