

*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: <i>Please explain any "Yes" answers in the space provided:</i>					

***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: <i>Please explain any "Yes" answers in the space provided:</i>			