L I N C O L N P E D I A T R I C G R O U P

CHILD'S NAME_____ **AGE**_____ **BIRTHDATE**_____ **DATE** _____

HISTORY FORM
(to be filled out by Parent)

A. PREGNANCY AND BIRTH:

1.	Did you have an illness during your pregnancy?	No	Yes
2.	Did the baby come on time?	Yes	No
3.	What was the birth weight?		_____
4.	Did your baby have any trouble starting to breathe?	No	Yes
5.	Did the baby have any trouble while in the hospital?	No	Yes

B. FEEDING AND DIGESTION:

1.	Was there severe colic or any unusual feeding problems the first 3 months?	No	Yes
2.	How was the baby fed as an infant?		_____
3.	Is your child's appetite usually good?	Yes	No
4.	Is it good now?	Yes	No
5.	Do any foods disagree with him/her?	No	Yes
6.	Does he/she often have diarrhea?	No	Yes
7.	Has constipation ever been much of a problem?	No	Yes
8.	If on vitamins, what kind and how much?		_____
9.	If still on formula, what one do you use?		_____

C. INFECTIONS, ILLNESSES, MISCELLANEOUS PROBLEMS AND DEVELOPMENT:

Has Your Child —

1.	Had as many as three attacks of ear trouble?	No	Yes
2.	Had more than three colds or throat infections with fever a year?	No	Yes
3.	Had any trouble with urination?	No	Yes
4.	Ever had a convulsion?	No	Yes
5.	Had any trouble with hearing?	No	Yes
6.	Had any trouble with vision?	No	Yes
7.	At what age did your child —		
	Sit alone?		_____
	Walk alone?		_____
8.	Did your child say any words by the age of 1½ years?	Yes	No
9.	Did your child have any bowel training problems?	No	Yes
10.	Does your child have any trouble sleeping?	No	Yes
11.	Does your child have dental problems?	No	Yes

Any Childhood Diseases?_____

Hospitalizations - For What?_____

Injuries? _____

D. IMMUNIZATIONS:

	Dates		Dates
DPT	_____	Measles	_____
Polio	_____	Mumps	_____
Hib	_____	Rubella	_____
Hepatitis B	_____		

E. ALLERGIES:

Has Your Child Ever Had —

1.	Eczema	No	Yes
2.	Hives	No	Yes
3.	Wheezing or asthma?	No	Yes
4.	Does he/she tend to have a stuffy nose or "constant cold?"	No	Yes
5.	Reactions to medications — what?		_____

F. BEHAVIOR — OLDER CHILDREN AND TEENAGERS:

Does Your Child—

1.	Get along well in school?	No	Yes
2.	Get along well with other children?	No	Yes

3. Have any of the following problems (circle):

nail biting	irritable	speech problems	thumbsucking
wets bed	bad temper	nightmares	won't mind
jealousy	breath holding	can't toilet train	