Medical History Form

Dr. Richard Solomon, MD

Date:

Child's Name	Birthdate	Age	
Home Address		Phone	
City	County	State	Zip Code

Your relationship to child:

❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other:

Father's name:	Birthdate:	Occupation:
Ethnic Background (optional)	Religion (optional)	
Mother's name:	Birthdate:	Occupation:
Ethnic Background (optional)	Religion (optional)	

Who referred you here for an evaluation?

What are your main concerns about your child?

When did you first have these concerns?

What have you been told about these concerns?

What things do you presently not understand about your child?

How do you think that we might be able to help you?

How you you feel your child can best be helped?

Pregnancy Questions in this section pertain to your pregnancy with this child.

Did you have any problems getting pregnant?

Was this a planned pregnancy? What were your feelings about being pregnant?

During which month of pregnancy did you start prenatal care? Where did you seek prenatal care?

What was your pre-pregnancy weight? How much weight did you gain during your pregnancy?

Did you have any weight loss during any part of this pregnancy? If so, when?

List any medicines taken during the pregnancy (include all medication, including vitamins, birth control pills, and aspirin, if taken frequently):

Did you smoke during this pregnancy? If so, how many cigarettes per day, and during which part of the pregnancy (early, middle, or late)?

Did you consume alcohol during this pregnancy? If so, how many drinks per week, and during which part of the pregnancy?

Did you take any medications during or just prior to this pregnancy?

Describe any illnesses during the pregnancy, and when they occurred (early, middle, or late):

Did you have any fever during the pregnancy? If so, during which part of the pregnancy? How high was the fever and how long did it persist?

Check any that apply and note any details:

- ❑ X-rays during or shortly before pregnancy?
- ❑ Vaginal bleeding?
- ❑ High blood pressure?
- ❑ Excessive morning sickness?
- ❑ Excessive swelling?
- ❑ Hospitalization?
- ❑ Operations?
- ❑ Accidents?
- ❑ Unusual worries?
- ❑ Special diet?

When did you first feel the baby move?

How were the baby's movements during pregnancy?

❑ Stronger than expected ❑ Weaker than expected ❑ About the same as expected

Birth History

Was the baby born on time, early, or late?

Was any stimulation of labor used? If so, what type?

What was the length of labor, in hours? How many hours were you in hard labor?

What was the length of time between water breaking and delivery?

Type of anesthesia or pain relief used, if any:

❑ Sedative ❑ Spinal or caudal ❑ Shot for pain relief ❑ Gas or Pentathol

Were you awake when the baby was born?

Type of delivery:

❑ Natural ❑ Cesarean ❑ Breech ❑ Forceps

Mother's blood group (ABO)	Mother's Ph factor
Baby's blood group (ABO)	Baby's Ph factor

Baby's birth weight	Birth length	Head circumference

Infant's condition:

❑ Breathed immediately ❑ Cried immediately

❑ Required oxygen ❑ Seizures or fits

Were there any problems during the first week (i.e., yellow skin, feeding difficulties, bleeding tendency, infection, needed an incubator, etc.)?

What medicines, if any, were given to the baby during the hospital stay?

List any later hospitalizations and surgeries (including outpatient) of child:

Name of hospital	Date	Reason

Health History

Was this child breast or bottle fed? Did the child eat well?

Sleep patterns: have there been any sleeping difficulties or night terrors?

What medications, if any, does the child take regularly?

Immunizations: ❑ Up to date ❑ Not up to date

Does your child have any allergies? If so, please list:

Check any that apply:

- ❑ Accidents
- ❑ Pneumonia
- ❑ Urine infection
- ❑ Constipation
- ❑ Speech problems
- ❑ Difficulty swallowing or chewing
- ❑ Drooling
- ❑ Frequent ear infections
- ❑ Birthmarks or skin disease
- ❑ Seizures or convulsions
- ❑ Rocking and/or head banging
- ❑ Temper tantrums
- ❑ High fever, unknown cause
- ❑ Anemia
- ❑ Problems with bladder or bowel control
- ❑ Vision problems
- ❑ Difficulty eating or feeding self
- ❑ Hearing problems
- ❑ Foot problems (any special shoes, braces, etc)
- ❑ Anxiety/unusual fears
- ❑ Obssesive compulsive behavior
- ❑ Discipline problems
- ❑ Ingestion of drugs, cleaners, or non-food items
- ❑ Other illnesses _____

Development

Regarding developmental milestones, indicate the age in months when your child first did each of the following. Please be as specific as possible in pinpointing the age. If your child has not yet reached a particular milestone, write “NA”. If you do not remember, please write “NR”.

Rolled over front to back	Recognized parents
Sat alone	Crawled
Stood unaided	Walked without assistance
Played pat-a-cake, peek-a-boo, or bye-bye	Ran with good control
Rode tricycle	Showed fear of strangers
Said first word	Repeated sounds others made
Repeated words others said	Toilet training started/finished
Combined different words	Dressed self
Said three single words	Used sentences
Used words with meaning (other than “ma-ma” or “da-da”)	Showed right- or left-hand tendency (indicate which)

Day Care and Schools

List all schools, including day care and pre-schools that this child has attended:

Has your child ever been held back in school?

Has your child ever been in special education? If so, when, where and what kind?

Has child ever had special tutoring? If so, when, where, and by whom?

Has your child ever received speech therapy? If so, when, where, and by whom?

Has your child received any other type of therapy? If so, please describe:

Are you aware of any problems at school? If so, please describe.

Activities

What things does your child like to do?

What things does your child do well?

What does your child find difficult?

Describe your child's indoor play.

Describe your child's outdoor play.

How does your child play and get along with other children?

Describe an average day for your child.

What do you like best about your child?

Dental History

Has your child ever been examined by a dentist? If so, for what reason?

When was your child's last dental visit?

Dentist's name and address:

Family History

Please indicate if there are any relatives of the child who have the same or similar problems for which you are seeking an evaluation. In addition, note any serious, chronic, or recurring illnesses or abnormalities, such as ADHD, learning disorders, speech or language issues, mental or emotional disorders (including depression), autism, convulsions or epilepsy, deafness, blindness, birth defects, miscarriages, cancer, leukemia, or thyroid disease (goiter). Please be as specific as possible, noting current age of the relative and the problem.

Mother	Mother's siblings
Mother's mother	Mother's father
Mother's aunts and uncles	Mother's cousins
Father	Father's siblings
Father's mother	Father's father
Father's aunts and uncles	Father's cousins

Describe any family tensions:

List support sources (such as relatives and friends) outside the immediate family:

Pregnancy History

List dates of past pregnancies. Indicate if the pregnancy resulted in a miscarriage, a threatened miscarriage (bleeding), premature birth, twins, deformity or other difficulty with live-born children or any other complications. Please list any birth defects, however unimportant you consider them to be.

Did you have any difficulty getting pregnant? If so, explain:

Are the mother and father cousins, or related in any other way?

List names and ages of siblings of the child being evaluated: