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PAST MEDICAL HISTORY:

Father's Name: ____
Mother's Name: ____
Patient's Name:____
Siblings' Names: ____

Please complete the questions below to the best of your knowledge:

Birth History:

Birthdate: _______________ Time:_______________
Hospital/Birthplace: ___________________________
Term: _____________________________________
Pregnancy No: ______________________________
Mother's Age: ______________________________
Any complications during pregnancy or delivery? Yes No
If yes please specify: ____
Delivery Type: Vaginal C-section
Instruments: Yes No
Induced: Yes No
Patient's blood type and group: __________________________________
Direct coombs if known: _______________________________________
Mother's Blood type and group if known: ___________________________

Birth Weight:____________ Length: __________ Apgar scores were _________ and __________
Jaundice: Yes No
Pass NB Hearing Test: Yes No
Initial physical examination was: normal abnormal
The hospital course was: complicated uncomplicated
Received Hepatitis B vaccine in hospital: Yes No
On what day was the infant discharged from hospital?____________
Birth anomalies: Yes No
Cardiovascular disease: Yes No
Renal disease: Yes No
Endocrine disease: Yes No
Other:____________________________________

Previous Illnesses:

Ear Infection: Yes No

Reflux: Yes No

Pneumonia: Yes No

Diabetes: Yes No

Asthma: Yes No

Kidney Disease: Yes No

Sinus Infections: Yes No

Thyroid Disease: Yes No

Tuberculosis: Yes No

Migraines: Yes No

Allergies (medication, food, or other). Please specify:____

____

Other: ____

Chronic Illnesses (if any):____________________________________

Previous Test:

Electrocardiogram: Yes No

CT/MRI: Yes No

X-ray: Yes No

Other:____

Surgical History:

Gallbladder: Yes No

Cancer Surgery: Yes No

Appendix: Yes No

Tonsillectomy: Yes No

Cardiac Catheter: Yes No

Other Surgeries: ____

Recent Hospitalizations (if any):

Date:

Place:

Duration:

Diagnosis/Reason:

Physical or Occupational Therapy: Yes No

If yes please specify:____

Followed by any specialist: Yes No

If yes please specify:____

Receiving any services (Early Intervention, Speech Therapy, etc.): Yes No

If yes please specify:____