

# HEALTH HISTORY

## AGES BIRTH TO 3 YEARS

If needed, please ask for assistance in completing this form.  
 Si necesita ayuda para llenar estas formas, por favor de decirnos nosotros le podemos ayuda.

Today's Date: \_\_\_\_\_

**PLEASE PRINT CLEARLY**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**BIRTH HISTORY**

Birth Weight: \_\_\_\_\_

	No	Yes	Explanation if needed
Was there any complications during the pregnancy? (ex: Maternal illness, smoking, alcohol, bleeding)			
Was the baby full term, premature or overdue?			
Was the delivery vaginal or C-section?			
Were forceps or vacuum required?			
Were there any other complications of the delivery?			
Did they have to give the baby oxygen or other assistance after birth?			
Was the baby in a special care nursery or have to stay in the hospital longer than usual?			
Was the baby breast fed? If So, How long?			
Was the baby bottle fed? If So, What type of formula was used?			
Were there any feeding problems?			

**DEVELOPMENT AND GROWTH**

Have there ever been concerns about the child's growth or nutrition? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_

Have there ever been concerns about the child's motor, verbal, or intellectual development? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain: \_\_\_\_\_

**BEHAVIOR**

How long does the child sleep at night? \_\_\_\_\_

Does the child take naps? \_\_\_\_ Yes \_\_\_\_ No If yes, how long? \_\_\_\_\_

If the child is toilet trained, does he or she have accidents? \_\_\_\_ Yes \_\_\_\_ No

What type of discipline is used? \_\_\_\_\_ How frequently? \_\_\_\_\_

Are there any problems at school or daycare? \_\_\_\_ Yes \_\_\_\_ No

How many hours of TV does he or she watch each day? \_\_\_\_\_

**ILLNESSES**

Has your child ever been hospitalized, had surgery or accidents or major illness? \_\_\_\_ Yes \_\_\_\_ No If yes, please explain below

Date	Reason

Has the child had Chicken Pox? \_\_\_\_ Yes \_\_\_\_ No If No, has the child been immunized for Chicken Pox (Varicella)? \_\_\_\_ Yes \_\_\_\_ No

**AUTHORIZATION AND RELEASE**

I certify to that I have read and understand the above information to the best of my knowledge.  
 The above questions have been accurately answered.

\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Printed Name

\_\_\_\_\_  
 Date