

HEALTH HISTORY

<input type="checkbox"/> no interval change	<input type="checkbox"/> Father working outside of home	<input type="checkbox"/> Mother working outside of home
<input type="checkbox"/> child care	<input type="checkbox"/> adequate food in house	<input type="checkbox"/> Type of child care
		<input type="checkbox"/> educational level
Family Situation: _____		
Changes since last visit: _____		

PRENATAL HISTORY

<input type="checkbox"/> smoking	<input type="checkbox"/> alcohol
<input type="checkbox"/> medications	<input type="checkbox"/> prenatal vitamins
Other Prenatal History: _____	

BIRTH HISTORY

birth weight	type of delivery
discharge weight	initial feeding
Duration of Gestation __ weeks	hospital inpatient
hospital	GBS status
mother's age	sepsis
<input type="checkbox"/> discharged with mother	<input type="checkbox"/> prenatal care provided
Concerns from nursery: _____	

PEDIATRIC MEDICAL HISTORY

<input type="checkbox"/> abandonment	<input type="checkbox"/> hepatitis
<input type="checkbox"/> alcohol	<input type="checkbox"/> HIV
<input type="checkbox"/> allergy	<input type="checkbox"/> immunocompromised disease
<input type="checkbox"/> anemia	<input type="checkbox"/> lack of adequate sleep
<input type="checkbox"/> asthma	menarche age
<input type="checkbox"/> bladder disease	<input type="checkbox"/> menstrual problems
<input type="checkbox"/> cancer	<input type="checkbox"/> menarche regularity
<input type="checkbox"/> cardiovascular disease	<input type="checkbox"/> obesity
<input type="checkbox"/> child with special needs	<input type="checkbox"/> poor health
<input type="checkbox"/> chronic illness	<input type="checkbox"/> poor vision
<input type="checkbox"/> diabetes type I	<input type="checkbox"/> pulmonary disease
<input type="checkbox"/> family problems	<input type="checkbox"/> recurrent bronchopulmonary infections
<input type="checkbox"/> fracture	<input type="checkbox"/> recurrent ear infections
<input type="checkbox"/> frequent sore throats	<input type="checkbox"/> skin problems
<input type="checkbox"/> gastrointestinal Disease	<input type="checkbox"/> thyroid disease
<input type="checkbox"/> gum disease	<input type="checkbox"/> under stress
<input type="checkbox"/> hearing problems	<input type="checkbox"/> varicella
SURGICAL HISTORY: _____	
OTHER MEDICAL HISTORY: _____	

PEDIATRIC SOCIAL HISTORY

<input type="checkbox"/> domestic violence	<input type="checkbox"/> physical abuse
race	native language
	religious status
Other Social History Details: _____	