



TODAY'S DATE: _____

FAMILY AND MEDICAL HISTORY FORM

PART 1 - GENERAL INFORMATION

CHILD'S FULL NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

HOME PHONE: _____

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES (Primary Caregivers)

FATHER'S NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

MOTHER'S NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO CHILD (please circle one): Biological Adoptive Step Foster Other

BIOLOGICAL PARENT INFORMATION (if not current caregiver or different from above):

FATHER'S/MOTHER'S NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE #: _____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD? _____

ADDRESS: _____

PHONE#: _____ WHEN IS CHILD IN THIS CHILDCARE? _____

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

<u>NAME</u>	<u>SEX</u>	<u>AGE</u>	<u>RELATIONSHIP TO CHILD</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



PART 2: PREGNANCY AND BIRTH HISTORY

Please list all pregnancies in order

PREGNANCY	BIRTH WEIGHT	ANY DELVIERY, HEALTH OR DEVELOPMENTAL PROBLEMS
1		
2		
3		
4		
5		
6		

PRENATAL HISTORY:

1. Did you have any problems getting pregnant? Please describe: _____

2. In what month did you begin prenatal care? _____

3. Please list all over the counter medications taken during this pregnancy and when (eg. vitamins, antacids, cold medications, aspirin etc): _____

4. Please list any cigarettes, caffeine, street drugs taken (how much a day and when in pregnancy): _____

5. Please list all prescription medications taken (name, dosage and from when to when): _____

6. Please give in pounds, the amount of total weight lost and/or gained during this pregnancy: _____

7. Did you have any of the following events occur during this pregnancy? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Allergies or asthma	
2			Anemia	
3			Diabetes/blood sugar problems	
4			Edema (swelling, water retention)	
5			Excessive vomiting	
6			Headaches/migraines	
7			Heart disease	
8			Kidney disease	
9			Pre-eclampsia	



ITEM	NO	YES	DESCRIPTION	EXPLANATION
10			Rh negative	
11			Toxemia	
12			Toxin exposure	
13			Accidents	
14			Bleeding/spotting	
15			Blood transfusions	
16			Cervical incompetence	
17			Infections (bladder or genital)	
18			Infections (other)	
19			Pre-term labor	
20			Uterine or uterine fluid problems	
21			Other physical injury	
22			Other not specified problem	

BIRTH HISTORY (for the child being evaluated):

- Hospital where born + city + state: _____
- Physician's Name: _____
- Gestational Age at time of delivery (or # weeks early or late): _____
- Length of Labor (in hours)? _____ Length of membrane rupture? _____
- Any type of labor stimulation and what was used? _____
- Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?
 Pain relief _____ Anti-vomiting _____
 Sedation _____ Anesthesia _____
- What type of delivery (please circle)? Vaginal Cesarean Section = elective or emergency
 Presentation: Head, Face, Breech, Transverse Reason for C-section _____
 Assistance: Forceps, Vacuum, other _____
- Did you experience any of the following problems during the labor/delivery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (why, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
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1			MATERNAL infection	
2			Low/high red/white blood cell count	
3			Pelvis or cervical problems	
4			Placenta problems	
5			Dysfunctional labor	
6			Baby had the cord around the neck	
7			Cord problems (knots, prolapsed, compression)	
8			Baby had very low or high heart rate	
9			Baby had heart rate decelerations	
10			Fetal distress was noted	
11			Meconium was noted	

9. How soon after the delivery did you see your baby _____

10. What was the baby's APGAR scores? 1 minute _____ 5 minute _____

11. What was the baby's Birth Weight? _____ Birth Length _____

12. Number of Days spent in the nursery? _____ NICU or Newborn Nursery? _____

13. What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Was blue/cyanotic at birth	
2			Required stimulation to breathe	
3			Required oxygen at birth	How much/what type?
4			Required resuscitation	
5			Was considered small for gestational age	
6			Had tremoring or seizures	Which/for how long?
7			Very low tone	
8			Brain hemorrhage	
9			Anemia and/or transfusions	Which/how many times?
10			Jaundice (yellow)	How much/how treated?
11			Had bruising	
12			Rh incompatibility problems	
13			Infections	
14			Congenital birth defects	
15			Aspiration (meconium or fluid)	Which/how treated?
16			Respiratory distress signs or syndrome	
17			Needed ventilation	What type/how long?
ITEM	NO	YES	DESCRIPTION	EXPLANATION



18			Choking or vomiting episodes	
19			Tube feedings	
20			Needed medications	

NUTRITIONAL HISTORY

Describe your child's feedings briefly from birth, noting any difficulties (breast/bottle fed, weaned when, introduced solids/table foods, colic/food allergies, growth/nutrition problems, feeding problems

PART 3: MEDICAL HISTORY OF CHILD

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below, making sure you include an explanation for any question answered "yes". In your explanation, please include your child's age(s) if relevant, any diagnoses made, and any treatments that have occurred.

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Frequent Colds/Respiratory Illness	
2			Frequent Strep throat/sore throat	
3			Frequent Ear Infections (?tubes)	
4			Birth defect/genetic disorder	
5			Lung condition/respiratory disorder	
6			Allergies or asthma	
7			Heart condition	
8			Anemia/blood disorder	
9			Kidney/Renal disorder	
10			Urinary problems/infections	
11			Hormonal problem	
12			Muscle disorder/muscle problem	
13			Joint or bone problems	
14			Fractured bones	
15			Skin disorder/skin problems (eczema)	
16			Visual disorder/vision problems	
17			Eye infections	
18			Neurological disorder	
19			Seizures or convulsions	
ITEM	NO	YES	DESCRIPTION	EXPLANATION

20		Stomach disorder/stomach pain	
21		Vomiting/digestion problems	
22		Failure to gain weight/feeding problems	
23		Constipation/diarrhea problems	
24		Dehydration episodes	
25		Hearing Loss/Ear disorder	
26		Significant accidents	
27		Head injuries or concussions	
28		Ingestion of toxins, poisons, foreign objects	
29		Major medical procedures (detail below)	
30		Chronic medications (for what? when? Name and dose)	
31		Any major childhood illness (pox, croup, measles, mumps, meningitis etc)	
32.		Hearing Assessments	

HOSPITALIZATIONS AND/OR SURGERIES:

List the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reasons.

1. _____
2. _____
3. _____

PRESENT HEALTH STATUS:

Most recent Height = _____ Weight = _____

Date: _____

Please note any illnesses for which your child is currently being treated, including their Current Medications:

PART 4: DEVELOPMENTAL HISTORY

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following INDEPENDENTLY. If you can not recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time or late. If your child has not yet achieved the milestone, write NA in the age column. Please also rate your estimation of the quality of your child's skills.

MILESTONE	AGE	EARLY	ON TIME	LATE	GOOD/FAIR	POOR
Smiled						
Held head up						
Rolled over						
Reached for an object actively						
MILESTONE	AGE	EARLY	ON	LATE	GOOD/FAIR	POOR



			TIME			
Transferred object between hands						
Sat unsupported						
Crawled						
Stood alone						
Walked by self						
Said first words						
Threw objects actively						
Ran by self						
Followed simple 1 step directions						
Said 2-3 phrases						
Ate unaided with a spoon/fork						
Dressed self						
Rode bicycle without training wheels						
Caught a thrown object						
Demonstrated handedness (which?)						
Knew colors						
Counted to 5						
Knew alphabet						
Bladder trained - days						
Bladder trained - nights						
Bowel trained						

1. Do you feel your child was "faster" or "slower" than his/her peers in any other way? Please explain

2. If your child is in school, please describe any difficulties or strengths in reading, writing or spelling: ____

3. Name of current school: _____ Grade: _____

Address: _____ Phone: _____

Any special education services (which, when)? _____

Teacher: _____

Describe any other concerns shared by the teacher: _____

5. Has your child had problems with any of the following (beyond expected for child's age):

ITEM	NO	YES	DESCRIPTION	EXPLANATION
1			Sleeping problems	
2			Bed wetting	
3			Drooling	
4			Thumb sucking	
5			Temper tantrums	
6			Head banging	
7			Breath holding	
8			Aggression/destructiveness	
9			Nervous habits (nail biting etc)	
10			Fire play or cruelty to animals	
11			Major mood swings	
12			Under or over reactive to sounds	
13			Under or over reactive to clothing	
14			Under or over reactive to taste	
15			Under or over reactive to smell	
16			Any unusual fears?	

PART 5: FAMILY MEDICAL HISTORY

Are there any of the following medical problems on either side of the child's BIOLOGICAL parents' families? If YES, please indicate on which side of the family, MOTHER or FATHER and explain WHO this is in relation to the CHILD. Please also explain if medications, surgery or hospitalizations were needed.

ITEM	N O	YES	DESCRIPTION	MOTHER'S OR FATHER'S SIDE	WHO?	EXPLANATION
1			Birth defects/Congenital disorder			
2			Neurological disorder or seizures			
3			Respiratory disease or tuberculosis			
4			Hormonal or Gland disorder			
5			Allergies - food or environmental (specify which for whom)			
6			Diabetes			
7			Stomach disease/disorder/problems			
8			Senses problems - vision, hearing, touch, taste, smell, balance			
9			Swallowing or feeding problems			
10			Attentional/learning problems			



ITEM	N O	YES	DESCRIPTION	MOTHER'S OR FATHER'S SIDE	WHO?	EXPLANATION
11			Hyperactivity			
12			Alcohol/drug problems			
13			Psychological/nervous issues			

Part 6: Communication History

What language is spoken in the home:

What are the individual's current difficulties with speech, language, and communication? Describe.

Has the individual received speech-language therapy in the past or does the individual currently receive speech-language therapy? Describe treatment goals.

Does the individual have a history of hearing difficulties (e.g., middle ear infections, hearing loss, etc.)? Please describe.

How does the individual currently communicate? Does the individual use gestures, sign language, or other forms of alternative/augmentative communication (e.g., picture symbols, word or alphabet board, etc)? Describe.

Is the individual's speech intelligible to
 familiar people? _____
 unfamiliar people? _____

Does the individual appear frustrated if he/she is not understood? Please describe.

Describe your concerns and what you hope to take from this evaluation:

PART 7: EATING/DRINKING

What are the individual's current difficulties with eating and drinking? When did the current difficulties with eating and drinking begin? Describe.

Describe the individual's appetite.

Describe a typical breakfast, lunch, and dinner for the individual.

What types of foods and liquids can the individual safely manage (e.g., regular liquid, thickened liquid, regular table food, soft table food, etc.)?

Does the individual prefer certain food or liquid tastes, textures, or temperatures? Describe.

Does the individual have difficulty with: (describe)

Voluntary opening or closing of mouth? _____

Sucking? _____

Biting on nipple, cup, or utensils? _____

Keeping food in mouth? _____

Chewing? _____

Food temperatures? _____

Food textures? _____

Food tastes? _____

Drinking from a cup or bottle? _____

Eating from a spoon? _____

Swallowing (e.g., food, liquid, medication, etc.)? _____

Choking/Gagging? _____

Reflux? _____

Tooth grinding? _____

