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CHILD REGISTRATION AND HISTORY RECORD

To be filled out by parent or guardian

Child's name_____
Date of birth_____

☐ **Male** ☐ **Female**

Delivery hospital _____

Your name_____
Relationship to child_____

ALLERGIES:

_____
_____
_____

List allergies to Medications, Xray dyes, Latex, or other ☐ **None** ☐ **Yes**
If yes, please list name(s) of medicine(s) and types(s) of reactions:

_____
_____
_____

Child and Family Medical History

Illnesses – Check if the child or members of the child's family (parents, siblings grandparents, aunts, uncles, have had the following illness or problems

	Child	Child's Family		Child	Child's Family
Frequent ear infections			Kidney/bladder problems or infections		
Frequent colds/sore throats			Seizures/convulsions		
Croup			Mumps, measles, chicken pox		
Wheezing/asthma			Early heart disease (age 50 or less)		
High Blood pressures			Pneumonia		
High cholesterol			Eye problems		
Lung disease/tuberculosis			Dental problems		
Sexually transmitted diseases			Hearing problems		
Alcohol use			Hay fever		
Emotional disorders/suicide attempts			Eczema/skin problems		
Cancer			Anemia/blood problems		
Diabetes			Smoking in the home		
Drug use			Other		

Hospitalizations or serious/unusual illnesses
Please list and include the dates

_____
_____
_____

Family Health

	First name	Year of Birth	Sex	Health Good	Health Poor	Explain
Mother				☐	☐	
Father				☐	☐	
Siblings				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Have any of the child's brothers or sisters died? **No** ☐ **Yes** ☐

Pregnancy and Birth

(circle answers please)

1. Were there any problems during the mother's pregnancy? Yes No
2. Did the mother use any cigarettes, alcohol, drugs or medications during pregnancy? Yes No
3. Did the baby come more than 2 weeks early or 2 weeks late? Yes No
4. What was the baby's birth weight? _____
5. Were there any problems during labor or delivery? Yes No
6. Was the delivery Vaginal? ❑ or C-section? ❑
7. Were there any problems during the nursery stay? Yes No

Development and Behavior Issues

	Yes	No
1. Did the child sit alone by 7 months?	❑	❑
2. Did the child walk alone by 14 months?	❑	❑
3. Did the child say 3 words by 15 months?	❑	❑
4. Is the child doing well in school?	❑	❑
5. Does the child get along well with other children?	❑	❑

6. Check off any of the following problems which the child has:

- ❑ Nightmares/sleep problems
- ❑ Irritable/bad temper
- ❑ Discipline problems
- ❑ Speech problems
- ❑ Thumb sucking
- ❑ Bedwetting
- ❑ Toilet training problems
- ❑ Breath holding

Health and Safety Issues

	Yes	No
1. Are there any guns in the child's house?	❑	❑
2. Does the child use a toothbrush daily?	❑	❑
3. Does the child use a car seat or seat belt all the time?	❑	❑
4. Are there smoke detectors in the child's home?	❑	❑
5. Is the hot water temperature less than 125 degrees?	❑	❑
6. Do you have rules/limits for television viewing?	❑	❑
7. Are medicines and potential poisons out of reach?	❑	❑
8. Do you have syrup of Ipecac in the home	❑	❑
9. Do you know child resuscitation or choking management?	❑	❑
10. Is the child sexually active?	❑	❑

Feeding and Digestion

1. Has the child had any unusual feeding problems? Yes No
2. Have there been any problems with diarrhea or constipation? Yes No
3. Is your drinking water fluoridated? Yes No
4. Does the child ever eat dirt, plaster, or paint? Yes No
5. How many meals does the child eat per day? _____
6. Does the child take vitamins, fluoride, iron, or other supplements? Yes No
7. Was/is this child breast-fed? Yes No

If discontinued, when?_____