Name: _____ Beacon Pediatrics – Child Health Date: _____

Birth History

1. Gestational Age (How on time was your child)
   _____ weeks
2. Birth Weight: _____
3. Birth Length: _____
4. Any complications during pregnancy?
   _____
   _____
5. Did mom drink alcohol during pregnancy Y N
6. Did mom smoke during pregnancy Y N
7. Was the delivery:
   Spontaneous Vaginal Delivery
   Induced Vaginal Delivery
   C-Section
   If induced or C-Section then why? _____
   _____
8. Delivery Complications? _____
   _____
9. Nursery Complications? _____
   _____
10. Mom's Name:_____
    Phone #_____
11. Dad's Name: _____
    Phone #_____
12. Age and Gender of Siblings:
    _____
    _____
    _____

Medical History – Has your child had?

Chicken Pox Disease	Y	N
Vaccine	Y	N
Asthma	Y	N
Allergies	Y	N
Dry Skin (Eczema)	Y	N
Ear Infections (>2/year)	Y	N
Feeding Problems	Y	N
ADD/ADHD	Y	N
Problems with BM (Stool)	Y	N
Problems with urination (pee)	Y	N
Growth/Language Delay	Y	N

List additional Medical Problems:
_____
_____
_____

Medications: (include doses)_____
_____
_____

Allergies: _____

Surgeries: _____
_____

Hospitalizations: _____
_____

Procedure (Age done): _____
_____
_____
_____

Social History:

Does your child Smoke	Y	N
Day Care?	Y	N
Home Mom/Dad	Y	N

Other family members who smoke: _____
_____
Pets? _____
Water? __bottled __nursery __Tidewater__Artesian __Well __Town

Family History of?

__Asthma	__Juvenile Diabetes	__Seizures
__Allergies	__Congenital Heart Dz	__Sickle Cell
__Migraines	__Childhood Cancers	__Other

Relatives	Age if living	Age and year of death	Current Illness	Cause of Death
Childs Mother				
Childs Father				

Additional Comments: