Personal History

PATIENT NAME _____ DATE _____

1. Did patient's mother have any illnesses or other problems during pregnancy? ☐ No ☐ Yes
2. Was child born at-or about-9 months? ☐ Yes ☐ No
3. What was his (her) birth weight? ☐ 5½-9# ☐ Other
4. Did (s)he have any trouble starting to breathe? ☐ No ☐ Yes
5. Did (s)he have any trouble in the hospital? ☐ No ☐ Yes
6. Was anything wrong with him/her when (s)he left the hospital? ☐ No ☐ Yes
7. Did (s)he sit, walk, talk at the same time as other children? ☐ Yes ☐ No
8. Has (s)he ever been back in the hospital since birth? ☐ No ☐ Yes
9. Has (s)he had any serious injuries? ☐ No ☐ Yes
10. Has (s)he had any operations? ☐ No ☐ Yes
11. Is (s)he allergic or had a reaction to any medicine or shots? ☐ No ☐ Yes
12. Has (s)he ever had eczema? ☐ No ☐ Yes
13. Is (s)he taking any medicine now? ☐ No ☐ Yes
14. Has (s)he ever eaten paint or plaster? ☐ No ☐ Yes
15. Does (s)he see well? ☐ Yes ☐ No
16. Has (s)he ever had "crossed eyes"? ☐ No ☐ Yes
17. Does (s)he hear well? ☐ Yes ☐ No
18. Does (s)he talk well for his/her age? ☐ Yes ☐ No
19. Has (s)he had more than 3 ear infections? ☐ No ☐ Yes
20. Has (s)he ever had a heart problem or Rheumatic Fever? ☐ No ☐ Yes
21. Has (s)he ever had wheezing/asthma? ☐ No ☐ Yes
22. Does (s)he often have vomiting, diarrhea, constipation? ☐ No ☐ Yes
23. Does (s)he have any trouble with urination? ☐ No ☐ Yes
24. Has (s)he ever had a kidney or urine infection? ☐ No ☐ Yes
25. Has (s)he ever had a seizure, "fit" or convulsion? ☐ No ☐ Yes
26. Does (s)he get along well with other children? ☐ Yes ☐ No
27. Frequent temper or crying spells? ☐ No ☐ Yes
28. Overly active or unusually quiet? ☐ No ☐ Yes
29. Any sleep problems? ☐ No ☐ Yes
30. Does (s)he have any dental problems? ☐ No ☐ Yes
31. Has (s)he had 3 DPT's (baby shots) and a Booster? ☐ Yes ☐ No
32. Has (s)he had a tuberculin test in the past 12 months? ☐ Yes ☐ No
33. Has (s)he had measles immunization? ☐ Yes ☐ No
34. Has (s)he had 3 day measles (Rubella) immunization? ☐ Yes ☐ No
35. Has (s)he had mumps immunization? ☐ Yes ☐ No
36. How many days of school has (s)he missed in the past 6 months? _____
37. Does (s)he attend any other clinics or doctors?

    Name _____
38. Has (s)he ever had
    ☐ Measles ☐ Chicken Pox
    ☐ Mumps ☐ Whooping Cough
39. How much milk does (s)he drink 24/hours? _____ oz.