

Tammy Maschino, M.D.
 Karyl Knopps, APRN-CNP
 Kimberly Edgmon, M.D.

VILLAGE CENTER PEDIATRICS
CHILD REGISTRATION AND HISTORY RECORD
 To be filled out by parent or guardian



Child's name _____ Date of Birth _____

Sex ___ M ___ F City of birth/delivery hospital _____

Pregnancy and Birth

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Were there any problems during the mother's pregnancy? <i>If yes, what problems?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Mother's age at birth _____ | | |
| 3. Did the mother use any cigarettes, alcohol, recreational drugs or medications during pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did the baby come more than 2 weeks early or 2 weeks late? <i>If yes, how many weeks (early or late)?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What was the baby's birth weight?
_____ | | |
| 6. Were there any problems during labor or delivery?
Vaginal <input type="checkbox"/> C-Section <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Anesthesia _____ | | |
| 8. Were there any problems during the nursery stay? <i>If yes, what problems?</i>
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Other problems _____ | | |
| 10. Number of days in the hospital
_____ | | |

Development and Behavioral Issues

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Does your child go to a sitter, attend daycare or preschool?
<i>If yes, where?</i> _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did the child sit alone by 7 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did the child walk alone by 14 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Did the child say 3 words by 15 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the child doing well in school? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does the child get along well with other children? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Check off any of the following problems which the child has:
<input type="checkbox"/> Nightmares/sleep problems
<input type="checkbox"/> Irritable/bad temper
<input type="checkbox"/> Discipline problems
<input type="checkbox"/> Speech problems
<input type="checkbox"/> Thumb sucking
<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Toilet training problems
<input type="checkbox"/> Breath holding | | |

Feeding and Digestion

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has the child had any unusual feeding problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any problems with diarrhea or constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your drinking water fluoridated? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the child ever eat dirt, plaster, or paint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. How many meals does the child eat per day? _____ | | |
| 6. Does the child take vitamins, fluoride, iron or other supplements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Was/is the child breast <input type="checkbox"/> or bottle <input type="checkbox"/> fed?
<i>If discontinued, when?</i> _____ | | |
| 8. Has the child ever required oxygen? IV? | <input type="checkbox"/> | <input type="checkbox"/> |

Health and Safety Issues

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are there any guns in the child's house? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the child use a toothbrush daily? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the child use a car seat or seat belt at all times? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are there smoke detectors in the child's home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the hot water temperature less than 125°? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have rules/limits for television viewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are medicines and potential poisons out of reach? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you know child resuscitation or choking management? | <input type="checkbox"/> | <input type="checkbox"/> |

Name of current school _____

Current grade in school _____

Usual grades made in school _____

SEE BACK