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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? *If yes, what problems?*______________________	☐	☐
2. Mother's age at birth ______________		
3. Did the mother use any cigarettes, alcohol, recreational drugs or mediations during pregnancy?	☐	☐
4. Did the baby come more than 2 weeks early or 2 weeks late? *If yes, how many weeks (early or late)?* ____________	☐	☐
5. What was the baby's birth weight? ___________________________		
6. Were there any problems during labor or delivery? Vaginal ☐ C-Section ☐	☐	☐
7. Anesthesia_________________		
8. Were there any problems during the nursery stay? *If yes, what problems?* _______________________________	☐	☐
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? If yes, where? ______________________	☐	☐
2. Did the child sit alone by 7 months?	☐	☐
3. Did the child walk alone by 14 months?	☐	☐
4. Did the child say 3 words by 15 months?	☐	☐
5. Is the child doing well in school?	☐	☐
6. Does the child get along well with other children?	☐	☐
7. Check off any of the following problems which the child has:		

- ☐ Nightmares/sleep problems
- ☐ Irritable/bad temper
- ☐ Discipline problems
- ☐ Speech problems
- ☐ Thumb sucking
- ☐ Bed wetting
- ☐ Toilet training problems
- ☐ Breath holding

Feeding and Digestion	Yes	No
1. Has the child had any unusual feeding problems?	☐	☐
2. Have there been any problems with diarrhea or constipation?	☐	☐
3. Is your drinking water fluoridated?	☐	☐
4. Does the child ever eat dirt, plaster, or paint?	☐	☐
5. How many meals does the child eat per day? _________________________		
6. Does the child take vitamins, fluoride, iron, or other supplements?	☐	☐
7. Was/is the child breast ☐ or bottle☐ fed? If discontinued, when? ____________		
8. Has the child ever required oxygen?	☐	☐
IV?	☐	☐

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 at all times?	☐	☐
4. Are there smoke detectors in the child's home?	☐	☐
5. Is the hot water temperature less than 125°?	☐	☐
6. Do you have rules/limits for television viewing?	☐	☐
7. Are medicines and potential poisons out of reach?	☐	☐
8. Do you know child resuscitation or chocking management?	☐	☐

Name of current school____

Current grade in school____________________________ Usual grades made in school ________________________

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Family History

Illnesses - Check □ where the child or members of the child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems.

	Child	Child's Family	Family Member		Child	Child's Family	Family Member
Bone Disease	□	□	__________	Developmental delay/ learning disorder	□	□	__________
Birth Defects	□	□	__________	Kidney/bladder problems or infections	□	□	__________
Frequent ear infections	□	□	__________	Seizures/convulsions	□	□	__________
Cystic fibrosis	□	□	__________	Heart disease	□	□	__________
Croup	□	□	__________	High blood pressure	□	□	__________
Mumps, measles, chicken pox	□	□	__________	High cholesterol	□	□	__________
Wheezing/asthma	□	□	__________	Lung disease/tuberculosis	□	□	__________
Pneumonia	□	□	__________	Sexually transmitted diseases/HIV	□	□	__________
Eye problems	□	□	__________	Alcohol/drug problems	□	□	__________
Dental problems	□	□	__________	Mental/emotional disorders	□	□	__________
Hearing problems	□	□	__________	Thyroid disease	□	□	__________
Hay fever/allergies	□	□	__________	Cancer	□	□	__________
Eczema/skin problems	□	□	__________	Migraines	□	□	__________
Anemia/blood problems	□	□	__________	Other______________________	□	□	__________
Arthritis	□	□	__________	Other______________________	□	□	__________
Ulcers/stomach problems	□	□	__________				
Diabetes	□	□	__________				

General Health				Health		
	First Name	Year of Birth	Sex	Good	Poor	(Explain)
Mother						
Father						
Brothers And Sisters						

Have any of the child's brothers or sisters died? No □ Yes □ (explain) ____

Hospitalizations or Serious/Unusual Illnesses

Identify any serious and/or unusual illnesses or injuries which your child has experienced.

Date	Serious/Unusual Illness/Injuries
______________	____
______________	____
______________	____
______________	____

Allergies

List allergies, including any allergic reactions to drugs.

Parent/Guardian Comments

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