

Personal, thoughtful, care for your children—from birth through college age

1455 25th Avenue Drive NE
Hickory, NC 28601-9677
Phone: (828) 322-4453
Fax: (828) 324-9295
www.thechildhealthcenter.com

ABBREVIATED NEWBORN HISTORY

Full Name of Child _____

Date of Birth _____

I. ENVIROMENT

- A. Water source (Please check): City Well Other _____
- B. Pets (list): _____ C. Farm Animals (list): _____
- D. School Performance and Behavior (Mother and Father)
- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. Mother's overall achievement (Please check):
Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/></p> <p>2. Mother's subject(s) of special difficulty _____</p> <p>3. Grades mother repeated (if any) _____</p> <p>4. Behavior _____</p> | <p>Father's overall achievement (Please check):
Below Average <input type="checkbox"/> Average <input type="checkbox"/> Above Average <input type="checkbox"/></p> <p>Father's subject(s) of special difficulty _____</p> <p>Grades father repeated (if any) _____</p> <p>Behavior _____</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

II. FAMILY HISTORY

Member	Name	Year of Birth	Health (if deceased, give cause)
Child's Father			
Child's Mother			
Sibling			
Sibling			
Sibling			
Sibling			

Is there any family history of the following (Please list and include grandparents, aunts, uncles, 1st cousins):

- | | |
|-------------------------------------------------------|------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Asthma (wheezing) _____ | <input type="checkbox"/> Childhood heart disease _____ |
| <input type="checkbox"/> Serious allergies _____ | <input type="checkbox"/> Birth defects _____ |
| <input type="checkbox"/> Diabetes ("sugar") _____ | <input type="checkbox"/> Death in first year of life _____ |
| <input type="checkbox"/> Convulsions (seizures) _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Mental retardation _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Blood disorders _____ | <input type="checkbox"/> Obesity (overweight) _____ |
| <input type="checkbox"/> Bleeding tendencies _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Thyroid disease _____ | <input type="checkbox"/> Heart attacks before age 50 _____ |
| <input type="checkbox"/> Liver disease _____ | <input type="checkbox"/> Strokes before age 60 _____ |
| <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Any other condition occurring in 2 or more family members _____ |
| <input type="checkbox"/> Rheumatic fever _____ | |

Form Completed by: _____ Relationship: _____ Date: _____