

APA History Form

Date	Child's Name	Nickname	DOB	M	F
Previous Physician/Office		Request for records transfer completed		Y N	
Date of Last Physical					
Mom's Name			Age		
Dad's Name			Age		
Child lives with			Form Completed by		

Birth History

Birth weight _____ Preg # _____ Mom's age _____ Was the baby born on time? _____ Early? _____ Late? _____ If early, how many weeks gestation? _____ Did mother have any illness or problems with her pregnancy? <input type="checkbox"/> Y <input type="checkbox"/> N Explain _____ During pregnancy, did mother: Smoke <input type="checkbox"/> Y <input type="checkbox"/> N Drink alcohol <input type="checkbox"/> Y <input type="checkbox"/> N Use drugs or medications <input type="checkbox"/> Y <input type="checkbox"/> N What _____ When _____	Was the delivery <input type="checkbox"/> Vaginal? <input type="checkbox"/> Cesarean? <input type="checkbox"/> Breech? If cesarean, why? _____ Did your baby have any problems right after birth? <input type="checkbox"/> Y <input type="checkbox"/> N Explain _____ _____ Was initial feeding <input type="checkbox"/> Breast milk? <input type="checkbox"/> Formula? Did your baby go home with mother from the hospital? <input type="checkbox"/> Y <input type="checkbox"/> N Explain _____
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Past History

Does your child have, or has he/she ever had:

Chickenpox	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Frequent ear infections or sore throats	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Nasal allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Problems with eyes, vision, or teeth	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Asthma, recurrent cough, bronchitis, or pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Blood transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Bladder or kidney infection	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Frequent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Convulsions or other neurologic problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Mental health issues (ADHD, anxiety, depression)	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Thyroid or other endocrine problem	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____

Other medical or mental health issues/problems _____

Does your child see any specialists? If so, who? For what reason or diagnosis? _____

General

Do you consider your child to be in good health?	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Does your child have any serious illnesses or chronic or medical conditions?	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Has your child had serious injuries or accidents?	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Has your child had any surgery?	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Has your child ever been hospitalized?	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____
Is your child allergic to any medicines or drugs or reacted to immunizations?	<input type="checkbox"/> Y <input type="checkbox"/> N	Explain _____

