Susan Raghavan, MD

Child's Name:---------- DOB:----------

Mother's Name:---------- Age:-
---------- Occupation:----------

Father's Name:---------- Age:-
---------- Occupation:----------

BIRTH HISTORY:
Mother's age at birth:----------Father's age:----------
Difficulty concieving: Yes-------- NO-------
Duration of Pregnancy: Fullterm----------Preterm----------
Normal Delivery----------C-Section----------

Problems during pregnancy----------
Problems during Delivery----------

Problems during 1st month in baby----------
Birth weight:---------- Length:----------

PAST MEDICAL HISTORY:
Other Illnesses:yes/no----------

Medications:yes/no----------

Hospitalisation:yes/no----------
Allergies to medications: yes/no----------
Growth Problems: yes/no----------
Immunisations: Complete/Incomplete----------
Surgeries: yes/no----------

DEVELOPMENT:
First smile: normal / late Head control: normal / late
Sitting up: normal / late Walking: normal / late
Speech: normal / late School performance: good / problematic
Speech: problems yes / no Behavioral problems: yes / no
Specify problems:----------

FAMILY HISTORY:
Other children: yes/ no Number:
Age Health status Problem(medical)

Problems in other family members: Diabetes Hypertension
Allergies Asthma Growth problems Puberty problems
Thyroid disease Heart disease Mental disorders HIV TB
Adrenal gland problems Oveweight Eating disorders
High Cholesterol

Mother's Height:----------
Father's Height:----------

Mother's age at puberty:----------
Father's puberty: normal age / late growth spurt----------

FEEDING HISTORY:
Breast feeding: yes / no Duration:----------
Bottle fed: yes / no Duration:----------

Feeding problems: yes / no specify:----------

MEDICATION HISTORY:
Thyroid Meds yes------no---dose---------duration----------

Growth hormone yes----no---dose---------duration----------

Steroids yes-----no----- dose----------duration----------

Birth control pills yes----no-----name---------duration-------

Herbal meds yes-----no-----name---------duration----------

Others----------

REVIEW OF SYSTEMS:PROBLEMS IN THE PAST
1. Eye problems—yes / no specify----------
2. Ear infections—yes / no specify----------
3. Deafness---yes / no specify----------
4. Sinus and throat problems—yes / no specify----------
5. Environmental allergies—yes / no specify----------
6. Asthma, pneumonia, RSV,respiratory---yes / no----------
7. Heart murmers—yes / no--specify----------
8. Jaundice, liver—yes / no--specify----------
9. Stomach problems—yes / no--specify----------
10.Kidney problems—yes / no--specify----------
11.Bladder problems—yes / no--specify----------
12.Nerve problems—yes / no--specify----------
13.Seisures—yes / no--specify----------
14.Fractures, joint problems—yes / no--specify----------
15.Problems with head size, hydrocephalus—yes / no----------
16.Testicular/ovarian problems—yes / no--specify----------
17.Skin conditions—yes / no--specify----------
18. Muscle problems—yes / no--specify----------
19.Spinal problems—yes / no--specify----------
20.Other specify----------

SOCIAL HISTORY:
Home Location City Suburban Rural
Exposure to animals Yes / No
NonParent Caregiver Babysitter Daycare Family members
School Public Private Special needs Home school
Smoking / alcohol / drugs at home Yes / no
Single parent Family Yes / no If yes
Lives with Mother / Father / Both / Other
Special Diet in Family Vegetarian / Vegan / Other
Childs Interaction with
1. adults- interacts easily shy scared
2. Children- Interacts easily shy scared
Recent Travel Abroad Yes / No
Recent Birth Of a Sibling Yes / No
Recent death in family Yes / No
Problems with parental unemployment Yes / No

REFERRED BY:----------

DATE:---------- Completed by:----------