Diagnoses

Diagnosis	Abbreviation	Also Called	Physician Who Diagnosed	Physician's Specialty	Date of Diagnosis

Test Results

Other

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed ______________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ______________________________________

Comments ____

____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed ______________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ______________________________________

Comments ____

____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed ______________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ______________________________________

Comments ____

____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed ______________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ______________________________________

Comments ____

____

____

____

Test Results

Other

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Comments ____

____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Comments ____

____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Comments ____

____

____

____

❑ Blood ❑ X-ray ❑ CT ❑ MRI ❑ Other____________ Date Performed _____________

Doctor who ordered test ____

Phone ____

Description ____

Results ____

Location of Test Record ____

Comments ____

____

____

____

Illnesses/Infections

Date _____

Doctor/Care Facility _____

Phone _____

Description _____

Results _____

Comments _____

_____

_____

_____

Date _____

Doctor/Care Facility _____

Phone _____

Description _____

Results _____

Comments _____

_____

_____

_____

Date _____

Doctor/Care Facility _____

Phone _____

Description _____

Results _____

Comments _____

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Doctor/Care Facility _____

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Comments _____

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Illnesses/Infections

Date _____

Doctor/Care Facility _____

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Doctor/Care Facility _____

Phone _____

Description _____

Results _____

Comments _____

_____

_____

_____

Date _____

Doctor/Care Facility _____

Phone _____

Description _____

Results _____

Comments _____

_____

_____

_____

Illness/Infection/Injury History

Illness/Infection/Injury	Date	Duration	Drugs Taken	Physician	Location	Treatment

Immunization Record

	Date	Physician	Reaction	Date	Physician	Reaction
Hepatitis A						
Hepatitis B						
Diptheria/Pertussis/Tetanus (DPT)						
Diptheria/Tetanus (DT)						
Tetanus						
HIB (Influenza Type B)						
Influenza (seasonal)						
Polio						
Rotavirus						
Pneumoccal						
Measles/Mumps/Rubella (MMR)						
Measles (Rubeola)						
Mumps						
Rubella						
Varicella						
Meningococcal Conjugate (MCV)						
HPV						
COVID 19						
PPD (TB test)						
Other:						
Lead Screening						

Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

Allergy Record

	Type	Reaction	Action to Take
Medications:			
Other:			

Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

Family Health History

Biological Family History

Mother's and Father's Health History

Allergies	❑ Mother	❑ Father
Asthma	❑ Mother	❑ Father
Birth Defects*	❑ Mother	❑ Father
Bone/Joint Problems	❑ Mother	❑ Father
Blood Disease (Type_____)	❑ Mother	❑ Father
Cancer (Type_____)	❑ Mother	❑ Father
Deafness	❑ Mother	❑ Father
Death under 50 years of age	❑ Mother	❑ Father
Diabetes	❑ Mother	❑ Father
Epilepsy, Seizures	❑ Mother	❑ Father
Heart Attack under 60 years of age	❑ Mother	❑ Father
High Blood Pressure	❑ Mother	❑ Father
High Cholesterol	❑ Mother	❑ Father
Intellectual Disability	❑ Mother	❑ Father
Kidney Problems	❑ Mother	❑ Father
Menstrual Problems*	❑ Mother	❑ Father
Muscle/Nerve Disease	❑ Mother	❑ Father
Smoker	❑ Mother	❑ Father
Stomach/Intestinal	❑ Mother	❑ Father
Stroke	❑ Mother	❑ Father
Urinary Problems	❑ Mother	❑ Father
Other*	❑ Mother	❑ Father

*Please explain:_____

_____

Family Health History

Is there anyone in the family with a similar disability or chronic illness as your child?

❑ Yes ❑ No

If yes, who/what: _____

_____

Is there anyone in the family with:			Relationship to child
Blood disorder	❑ Yes	❑ No	_____
Cancer	❑ Yes	❑ No	_____
Cerebral Palsy	❑ Yes	❑ No	_____
Cleft Palate	❑ Yes	❑ No	_____
Developmental disabilities	❑ Yes	❑ No	_____
Diabetes	❑ Yes	❑ No	_____
Genetic conditions	❑ Yes	❑ No	_____
Heart problems	❑ Yes	❑ No	_____
Metabolic or nutritional disorder	❑ Yes	❑ No	_____
Seizure disorder	❑ Yes	❑ No	_____
Vision and/or hearing impairment	❑ Yes	❑ No	_____
Other _____	❑ Yes	❑ No	_____

Has anyone in the family had genetic testing or counseling?

❑ Yes ❑ No ❑ Don't know If yes, please describe:_____

_____

Are there any other family health information that might be related to your child's special health needs? _____

_____

Birth History

Child's Name _____

Date of Birth ____/_____/_____ Birthweight _____ Length _____

Birth Order (1st, 2nd, etc.) _____

Obstetrician _____

Address _____City_____State_____ Zip _____

Phone _____ Cell _____ Email _____

Hospital where child was born _____

Address _____City_____State_____ Zip _____

Phone _____

Name of child's primary doctor _____

Address _____City_____State_____ Zip _____

Phone _____

Notes

How many months were you pregnant when you first saw a doctor? _____

How many times did you visit the doctor during your pregnancy? _____

Drugs/medications taken during pregnancy: _____

_____

Any illnesses or problems during the pregnancy?

❑ Yes ❑ No If yes, please describe:_____

_____

Was the baby full-term (37 weeks or more)?

❑ Yes ❑ No If no, number of weeks of gestation? _____

Length of labor _____

Delivery method: ❑ Normal ❑ Caesarean ❑ Breech ❑ Precipitate (sudden)

Child's Apgar scores at 1 minute_____; at 5 minutes_____

Child's condition at birth _____

_____

Child was fed: ❑ breast milk ❑ formula (brand_____)

Child's age at hospital discharge _____

Child was in the hospital from ____/_____/_____ to ____/_____/_____

Milestones

Developmental Milestones

	Age	Notes/Questions
Smiled	_____	_____
Laughed out loud	_____	_____
Held up head	_____	_____
Rolled over	_____	_____
Sat up	_____	_____
Sat alone	_____	_____
Got first tooth	_____	_____
Started solid food	_____	_____
Drank from glass/cup	_____	_____
Used utensils	_____	_____
Crawled	_____	_____
Spoke first word	_____	_____
Waved “bye”	_____	_____
Walked	_____	_____
Walked alone	_____	_____
Spoke first sentence	_____	_____
Toilet		
Indicated need	_____	_____
Toilet trained – bladder	_____	_____
Toilet trained – bowel	_____	_____
Dressed self	_____	_____
Washed self	_____	_____
Other _____	_____	_____
Other _____	_____	_____

Notes

Eating History

When your child came home from the hospital, what type of food did he/she eat:

❑ breast milk ❑ regular formula ❑ special formula ❑ other_____

Changes in feeding

Breast to bottle child's age _____ why change? _____

_____

Formula change child's age_____why change and changed to what?_____

_____

Bottle to cup child's age _____ why change? _____

_____

Started solid food child's age _____

Food allergies _____

_____

Textures _____

_____

NPO & Tube Feedings _____

_____

Other changes _____

_____

_____

How long does it take your child to finish a bottle or eat a meal? _____

_____

_____

Are there any problems (vomiting, choking, swallowing, refusing to eat, diarrhea, etc.)?

_____

_____

_____

Notes

Dental History

Dentist _____

Address _____City_____State_____ Zip _____

Phone _____ Cell _____ Email _____

Dental Specialist _____

Address _____City_____State_____ Zip _____

Phone _____ Cell _____ Email _____

Date	Appointment Time	What Occurred at Appointment	Follow-up Information (Sedation provided/Antibiotics Given/Needed)

Notes