

**MEDICAL HISTORY**

**CHILD'S NAME :** \_\_\_\_\_ **DATE OF BIRTH :** \_\_\_\_\_

**PREGNANCY AND BIRTH**

What problems, if any were experienced during pregnancy? \_\_\_\_\_  
 Was the child premature ? \_\_\_\_\_ By how long ? \_\_\_\_\_  
 Was the child delivered by caesarean ? \_\_\_\_\_ Forceps \_\_\_\_\_ Other \_\_\_\_\_  
 Was the child placed in an incubator, if so for how long and why ? \_\_\_\_\_  
 Did the child receive any other treatment after birth eg. for jaundice, breathing problems ?  
 \_\_\_\_\_  
 For how long was the child breastfed ? \_\_\_\_\_ Bottlefed ? \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

At what age did the child :  
 Sit up : \_\_\_\_\_  
 Crawl : \_\_\_\_\_  
 Stand : \_\_\_\_\_  
 Walk : \_\_\_\_\_  
 Talk : \_\_\_\_\_  
 Become fully toilet trained : \_\_\_\_\_

**INNOCULATIONS**

BCG : \_\_\_\_\_ age : \_\_\_\_\_  
 Diphtheria : \_\_\_\_\_ age : \_\_\_\_\_  
 Tetanus : \_\_\_\_\_  
 Whooping cough : \_\_\_\_\_  
 Polio : \_\_\_\_\_ age : \_\_\_\_\_

**OPERATIONS AND ILLNESSES**

Please give any details of operations, and at what age they were performed on the child :  
 \_\_\_\_\_  
 \_\_\_\_\_

How long was the child in hospital ? \_\_\_\_\_  
 Was he/she accompanied by a parent on a "live-in" basis ?  
 \_\_\_\_\_

Do you feel your child suffered any serious emotional upsets due to the stay in hospital, if so give details ?  
 \_\_\_\_\_

Tick any of the following illnesses suffered by the child :

Croup \_\_\_\_\_ Chickenpox \_\_\_\_\_ Asthma \_\_\_\_\_  
 German Measles \_\_\_\_\_ Measles \_\_\_\_\_ Ear Infections \_\_\_\_\_  
 Mumps \_\_\_\_\_ Urinary Infections \_\_\_\_\_ Eye Infections \_\_\_\_\_  
 Scarlet Fever \_\_\_\_\_ Meningitis \_\_\_\_\_ Whooping Cough \_\_\_\_\_  
 Encephalitis \_\_\_\_\_ Any other \_\_\_\_\_



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Does your child have grommets \_\_\_\_\_

When were they inserted \_\_\_\_\_

Has the child ever broken a limb ? Give details \_\_\_\_\_

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Any other physical handicaps / congenital illnesses ? \_\_\_\_\_

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ALLERGIES

Is your child allergic to any of the following ?

Bee stings \_\_\_\_\_ Milk \_\_\_\_\_

Antibiotics \_\_\_\_\_ Other food \_\_\_\_\_

Analgesics \_\_\_\_\_ Dust, pets etc \_\_\_\_\_

Any other allergies \_\_\_\_\_

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GENERAL

Do you have a family history of dyslexia, hyperactivity, minimal brain dysfunction or other learning problems ?

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