# Medical History

Patient Name: _____

**Pregnancy / Delivery**

Pregnancy Proceeded ☐ With Complications

- ☐ Eclampsia
- ☐ Gestational Diabetes
- ☐ Multiple Births
- ☐ Positive for Cytomegalovirus 'CMV'
- ☐ Positive for Herpes
- ☐ Positive for HIV
- ☐ Positive for Strep B
- ☐ Pre-eclamsia
- ☐ Premature Labor
- ☐ Substance Exposure
- ☐ Toxemia
- ☐ Other _____

☐ Without Complications

Length of Pregnancy (in weeks)_____ Prenatal care was ☐ Received ☐ Not Received

Mothers age at time of birth _____ Birth Hospital _____

Needed to be transfered to another hospital ☐ Yes ☐ No Transfer Hospital_____

Delivery Proceeded ☐ With Complications

- ☐ Abruptio Placenta
- ☐ Breech Presentation
- ☐ Negative Vacuum
- ☐ Placenta Previa
- ☐ Premature Rupture of Membranes
- ☐ Prolapsed Cord
- ☐ Transverse Presentation
- ☐ Umbilical Cord Wrapped Around Neck
- ☐ Use of Forceps
- ☐ Uterine Rupture
- ☐ Other _____

☐ Without Complications

Deliver was ☐ Vaginal ☐ C-section ☐ Emergency C-section Days in Hospital_____

Birth Weight _____ Birth Height _____ Apgar 1 min _____ 5 min _____ 10 min _____

Comments

**Following Birth**

Complications Following Birth

- ☐ Anemia of Prematurity
- ☐ Brohopulminary Dyspasia 'BPD'
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Club Foot
- ☐ Cytomegalovirus
- ☐ ECMO
- ☐ Faiture to Thrive
- ☐ Hyperbilirubinemia
- ☐ Intrauterine Growth Retardation 'IUGR'
- ☐ IVH Bleed Grade I
- ☐ IVH Bleed Grade II
- ☐ IVH Bleed Grade III
- ☐ IVH Bleed Grade IV
- ☐ Maconium Aspiration
- ☐ Necrotizing Enterocolitis 'NEC'
- ☐ Neonatal hypoxia
- ☐ Oxygen dependency
- ☐ PDA
- ☐ Positive dependency
- ☐ Respiratory Distrress Syndrome
- ☐ Respiratory Stridor
- ☐ Respiratory Syncytial Virus 'RSV'
- ☐ Retinopathy of Prematurity 'ROP'
- ☐ Ventilator Dependency
- ☐ VP Shunt

Diagnosed or Suspected Syndromes

**Health Issues**

- ☐ Anoxic Brain Injury
- ☐ Arteriovenous Malformation 'AVM'
- ☐ Asthma / Respiratory
- ☐ Cerebral Vascular Accident 'CVA'
- ☐ Chronic Ear Infections
- ☐ Colic
- ☐ Consitpation / Diarrhea
- ☐ Reflux
- ☐ Seizure Disorder
- ☐ Sleep Problems
- ☐ Traumatic Brain Injury 'TBI'
- ☐ Tube Feedng

Alergies

Current Medications

Current Vitamins, Herbs, Minerals, Homeopathics

**Hearing Test**

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Test Date _____

Results

Concerns

**Vision Test**

- ☐ Never Tested, No Concerns
- ☐ Never Tested, Have Concerns
- ☐ Normal Test Results
- ☐ Abnormal Test Results

Test Date _____

Results

Concerns

| Specialists Seen | | |
|---|---|---|
| **Specialist** | **Name** | **Reason** |
| Allergist | | |
| Audiologist | | |
| Cardiologist | | |
| Developmental Medicine | | |
| Endocrinologist | | |
| ENT | | |
| Gastroenterologist | | |
| General Surgeon | | |
| Geneticist | | |
| Hand Surgeon | | |
| Internal Medicine | | |
| Nephrologist | | |
| Neuro-Surgeon | | |
| Neurologist | | |
| OBGYN | | |
| Oncologist | | |
| Opthamologist | | |
| Orthopedic Surgeon | | |
| Pediatrician | | |
| Physiatrist | | |
| Podiatrist | | |
| Psychiatrist | | |
| Rheumatologist | | |
| Thoracic Surgeon | | |
| Urologist | | |

| Diagnostic Tests | | |
|---|---|---|
| **Test** | **When** | **Results** |
| ABR/ BAER | | |
| Blood Work / Lab Tests | | |
| Bone Density Scan | | |
| CT Scan | | |
| EEG | | |
| EMG | | |
| Lower GI | | |
| Motility Study / Empty Scan | | |
| MRI | | |
| NCV | | |
| Swallow Study | | |
| Upper Endoscopy | | |
| X-Ray | | |

| Surgeries and Procedures | | | |
|---|---|---|---|
| **Type** | **When** | **Age** | **Results** |
| | | | |
| | | | |
| | | | |

**Contraindications / Precautions**

- ☐ Allergies
- ☐ Baclofen Pump
- ☐ Braces
- ☐ Osteoporosis
- ☐ Seizure Condition
- ☐ Shunts
- ☐ Tube Feeding
- ☐ Vagal Nerve Stimulator
- ☐ None

**Medical Conditions**

**Orthopedic Conditions**

**Developmental History**

| Motor / Sensory / Plan | | | |
|---|---|---|---|
| **Milestone** | **When (in months)** | **Milestone** | **When (in months)** |
| Creeps / Crawls Alone | | Rolls Over | |
| Grabs Toys | | Sits Alone Without Support | |
| Holds Head Up Alone | | Walks Unaided | |
| Pulls Self to Standing Position | | | |

How does child get around the house?

Favorite Toys / Play Activities

☐ Yes ☐ No Does child fall or lose balance easily? Is your child ☐ Right ☐ Left ☐ Neither

☐ Yes ☐ No Child visually looks at people and/or toys?

☐ Yes ☐ No Child show a negative response when touched or when touching other objects?

☐ Yes ☐ No Child enjoy movement such as swinging or roughhousing?

☐ Yes ☐ No Child play and/or participate in leisure activities daily?

☐ Yes ☐ No Child involved in community programs (school, special rec., scouts, etc.)?

**Feeding / Speech / Language**

Describe Any Feeding Problems

Food Likes

Food Dislikes

| Feeding / Speech / Language | | | |
|---|---|---|---|
| **Milestone** | **When (in months)** | **Milestone** | **When (in months)** |
| Begin Eating Baby Food | | Name Familiar Objects | |
| Begin Eating Junior Food | | Using a Bottle | |
| Begin Eating Table Food | | Using A Pacifier | |
| Begin Using A Cup, Sippy Cup, Straw | | Use Two-Word Combinations | |
| Complete Sentences | | | |

**Areas of Difficulty**

☐ Chewing ☐ Drooling ☐ Transitioning Between Foods
☐ Communication Needs ☐ Swallowing ☐ Understanding Words

**Primary Communication**

☐ Non-Verbal ☐ Body Language
☐ Body Language ☐ Manual Sign Language ☐ Phrases ☐ Single Words
☐ Eye Gaze ☐ Pointing / Gesturing ☐ Sentences ☐ Vocalizations
☐ Facial Expressions

Augmentative Communication Device _____

First Words _____

Description of Child

☐ Active ☐ Curious ☐ Fearless ☐ Persistent
☐ Affectionate ☐ Demanding ☐ Fussy ☐ Playful
☐ Aggressive ☐ Difficult to Comfort ☐ Insecure ☐ Shy
☐ Calm ☐ Distractible ☐ Motivated ☐ Stubborn
☐ Cautious ☐ Fearful ☐ Passive ☐ Withdrawn

**Primary Communication**

Grade in School _____ Name of School _____

☐ Yes ☐ No Does your child have an IEP from school?
☐ Yes ☐ No Has your child had a psychological or neuropsychological evaluation completed?

| **Therapy Services** | **Type** | **Status** | **Where** | **Frequency/Duration** |
|---|---|---|---|---|
| Assistive Technology | | | | |
| Audiology | | | | |
| Behavior Therapy | | | | |
| Developmental History | | | | |
| Intensive Suit Therapy | | | | |
| Nutrition | | | | |
| Occupational Therapy | | | | |
| Physical Therapy | | | | |
| Social Therapy | | | | |
| Speech / Language Therapy | | | | |
| Vision Therapy | | | | |