TODAY'S DATE: _____

Easter Seals DuPage and the Fox Valley Region

MEDICAL HISTORY FORM

(Please Print)

PATIENT INFORMATION

Legal Name: First _____ MI _____ Last _____

Diagnosis/suspected syndrome, if any: _____

Current Height: _____ Ft. _____ Ins. Current Weight: _____ Lbs. _____ Oz.

PARENT CONCERNS

Reason for Evaluation: Please be specific.	

MEDICAL HISTORY

Pregnancy proceeded: ☐ Normally ☐ With complications ☐ Adopted, history not known Prenatal care was: ☐ Received ☐ Not received

Please indicate complicating conditions:

☐ Eclampsia ☐ Positive for cytomegalovirus (CMV) ☐ Positive for strep B ☐ Substance exposure

☐ Gestational diabetes ☐ Positive for herpes ☐ Pre-eclampsia ☐ Toxemia

☐ Multiple births ☐ Positive for HIV ☐ Premature labor ☐ Other: _____

Length of pregnancy: _____ Weeks Mother's age at time of birth: _____ Yrs.

Birth Hospital: _____ Was the baby transferred to another hospital? ☐ Yes ☐ No Transferred hospital: _____

Delivery was: ☐ Vaginal ☐ C-Section ☐ Emergency C-Section

Were there complications during delivery? ☐ Yes ☐ No

☐ Abruptio placenta ☐ Negative vacuum ☐ Prolapsed cord ☐ Uterine rupture

☐ Anoxic brain injury ☐ Placenta previa ☐ Umbilical cord wrapped around the neck ☐ Transverse presentation

☐ Breech presentation ☐ Premature rupture of membranes ☐ Use of forceps ☐ Traumatic Brain Injury (TBI)

☐ Other: _____

Birth weight: _____ Lbs. _____ Oz. Birth Length: _____ Ins.

Apgars (if known): 1 minute _____ (1-10)

5 minute _____ (1-10)

10 minute _____ (1-10)

Baby's length of stay in hospital: _____ Days

Were there significant complications following birth? ☐ Yes ☐ No

Please indicate significant complications:

☐ Anemia or prematurity	☐ Failure to thrive	☐ Positive dependency
☐ Arteriovenous Malformation (AVM)	☐ Hyperbilirubinemia	☐ Respiratory Distress Syndrome
☐ Brochopulmonary dysplasia (BPD)	☐ Intrauterine Growth Retardation (IUGR)	☐ Respiratory stridor
☐ Cerebral Vascular Accident (CVA)	☐ IVH Bleed Grade _____ (I-IV)	☐ Respiratory Syncytial Virus (RSV)
☐ Cleft lip	☐ Meconium aspiration	☐ Retinopathy of Prematurity (ROP)
☐ Cleft palate	☐ Necrotizing Enterocolitis (NEC)	☐ Ventilator dependency
☐ Club foot	☐ Neonatal hypoxia	☐ VP shunt
☐ Cytomegalovirus	☐ Oxygen dependency	☐ Other
☐ ECMO	☐ PDA	

Childhood Health Issues:

☐ Asthma/respiratory ☐ Constipation/diarrhea ☐ Sleep problems

☐ Chronic ear infections ☐ Reflux ☐ Tube feeding

☐ Colic ☐ Seizure disorder – date of last seizure _____ ☐ Other: _____

Hearing Testing:

☐ Never tested, no concerns

☐ Normal test results Date: _____ (mo/yr)

☐ Abnormal test results Date: _____ (mo/yr) Describe: _____

☐ Never tested, have concerns – Describe: _____

Vision Testing:

☐ Never tested, no concerns

☐ Normal test results Date: _____ (mo/yr)

☐ Abnormal test results Date: _____ (mo/yr) Describe: _____

☐ Never tested, have concerns – Describe: _____

Current Medications:

Medication	Prescribing Physician	Prescribing Physician's Phone (Required)

Current Vitamins, herbs, minerals, homeopathics:

SPECIALISTS SEEN:		
Specialist	**Name/Location**	**Date Last Seen**
☐ Audiologist		
☐ Cardiologist		
☐ Developmental Medicine		
☐ ENT		
☐ Gastroenterologist		
☐ Geneticist		
☐ Ophthalmologist		
☐ Pediatrician		
☐ Physiatrist		
☐ Psychiatrist		
☐ Pulmonologist		
☐ Surgeon – Specialty: _____		
☐ Other: _____		

Diagnostic Tests:

	When	**Where**	**Results**
ABR/BAER			
Blood Work/Lab Tests			
EEG			
EMG			
CT Scan			
MRI			
Swallow Study			
X-Ray (include hip/spinal)			
Other:			

List any previous surgeries (include age at time of surgery). Please use a separate sheet, if necessary.

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

List any previous procedures (indicate when procedure was done):

☐ Botox injections Body Location: _____ When: _____

☐ Hyperbaric Oxygen Treatments When: _____ Where: _____

☐ Other: _____

CONTRAINDICATIONS/PRECAUTIONS:

(Physician's prescription must include any precautions needed for treatment)

☐ None ☐ Osteoporosis ☐ Shunts ☐ Vagal nerve stimulator

☐ Baclofen pump ☐ Seizure condition ☐ Tube feeding

Allergies (include latex) **Please list:**	
Medical Conditions **Describe:**	
Orthopedic Conditions **Describe:**	
Comments:	

DEVELOPMENTAL HISTORY

Motor

At what age did your child: Age (optional if child is over 10 years of age):

Hold head up alone _____ Crawl/creep alone _____

Roll over _____ Walk unaided _____

Sit alone without support _____

Feeding, Speech, and Language

Does your child have any feeding problems? ☐ Yes ☐ No

If yes, please describe: _____

_____

When did your child: Age (optional if child is over 10 years of age)

Stop using a bottle _____

Begin eating - Baby food _____

- Table foods _____

Please list food preferences: _____

Dislikes: _____

1.) How does your child communicate his/her needs? Provide examples. _____

_____

2.) Do you have concerns with your child's social interactions? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please check any of the following that currently describe your child:

☐ Affectionate ☐ Calm ☐ Demanding ☐ Fearful ☐ Playful ☐ Withdrawn ☐ Fussy

☐ Aggressive ☐ Motivated ☐ Distractible ☐ Fearless ☐ Shy ☐ Cautious ☐ Insecure

☐ Active ☐ Curious ☐ Difficult to Comfort ☐ Persistent ☐ Stubborn ☐ Passive

School History

Is your child in school? If so, what grade? _____ Where: _____ District: _____

Does your child participate in any community programs? ☐ Yes ☐ No If yes, please list: _____

Therapy History

Has your child ever received any of the following services?

Therapy	Type	Where:
☐ Physical Therapy	☐ Individual ☐ Group ☐ On-going	
☐ Occupational Therapy	☐ Individual ☐ Group ☐ On-going	
☐ Speech/Language Therapy	☐ Individual ☐ Group ☐ On-going	
☐ Social Work	☐ Individual ☐ Group ☐ On-going	
☐ Assistive Technology	☐ On-going	
☐ Nutrition	☐ On-going	
☐ Vision Therapy	☐ On-going	
☐ Audiology	☐ On-going	
☐ Behavior Therapy	☐ On-going	
☐ Developmental Therapy	☐ On-going	
☐ Intensive Suit Therapy	☐ On-going	

If yes to any of the preceding services, please describe frequency and duration.

_____

_____