

DATE: \_\_\_\_\_

DR. MANORAMA MATHUR  
1127 Salem St., Malden, Ma 02148  
(617) 324-0242

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ DOB \_\_\_\_\_

We will provide your child with the best medical care possible. You can participate in that care by answering the following:

**Pregnancy & Birth**

1. Planned \_\_\_\_\_ or Unplanned \_\_\_\_\_
2. Mother's age at the time of the delivery \_\_\_\_\_
- A. Number of pregnancies \_\_\_\_\_ B. Birth order of child \_\_\_\_\_
3. Who was your primary care physician before this baby was born? \_\_\_\_\_
4. Did you suffer any illness during your pregnancy? \_\_\_\_\_
5. Did you ever take any medication during your pregnancy? \_\_\_\_\_
6. Was the baby born on schedule? \_\_\_\_\_  
A. Type of delivery \_\_\_\_\_ B. Type of Anesthesia \_\_\_\_\_
7. What was baby's weight at birth? \_\_\_\_\_
8. At the time of birth, did the child have any difficulty breathing? \_\_\_\_\_
9. Were there any complications, while the child was at the hospital? \_\_\_\_\_  
If so, explain: \_\_\_\_\_
10. In which hospital was your child born? \_\_\_\_\_

**DEVELOPMENTAL**

1. At what age did your child begin to sit on his/her own? \_\_\_\_\_
2. When did your child begin to walk? \_\_\_\_\_
3. At what age did your child speak his/her first words? \_\_\_\_\_
4. When was the child toilet trained? \_\_\_\_\_

**PAST ILLNESSES**

Has your child ever suffered from the following:

- |  |  |
|--|--|
| More than three ear infections?..... yes / no                      | More than six colds or throat infections? ..... yes / no   |
| Trouble passing urine? ..... yes / no                              | Convulsions? ..... yes / no                                |
| Fainting spell? ..... yes / no                                     | Problems with vision? ..... yes / no                       |
| Trouble hearing? ..... yes / no                                    | Has your child ever had a hearing test?..... yes / no      |
| Has your child ever had a vision test? .. yes / no                 | Difficulty sleeping/ insomnia? ..... yes / no              |
| Has he/she recently seen a dentist? ..... yes / no                 | Has your daughter had first menstrual period? ... yes / no |
| Has your son shown any signs of sexual development? ..... yes / no |  |

**PLEASE TICK ANY OF THE FOLLOWING THAT YOUR CHILD HAS HAD:**

- |                            |                   |                         |
|----------------------------|-------------------|-------------------------|
| Intestinal Parasites _____ | Chicken Pox _____ | Bleeding problems _____ |
| Whooping Cough _____       | Mumps _____       | Broken bones _____      |
| German Measles _____       | Jaundice _____    | Scarlet fever _____     |
| Stomach problems _____     | Anemia _____      | Heart problems _____    |
| Measles _____              | Rubella _____     | Other: _____            |

- Has your child ever been in any serious accident(s)? yes / no      Has your child ever been operated on?.... yes / no
- Did your child ever have to stay in a hospital overnight? ..... yes / no

If so:

- A. What hospital? \_\_\_\_\_
- B. Date of when this occurred? \_\_\_\_\_

**ALLERGIES**

