**Livermore Pleasanton San Ramon Pediatrics**

Stanford Children's Health

Birth date: _____ Child's Name: _____

Hospital: _____ Male ☐ Female ☐

City/State: _____

Today's Date: _____ Relationship of person filling out form to child: _____

## Pregnancy – Birth History – Family History

*(Place a check mark on response.)*

| | Yes | No |
|---|---|---|
| Did mother have health problems during pregnancy? | _____ | _____ |
| Did mother smoke, drink, or take drugs during pregnancy? | _____ | _____ |
| Was baby born on time? (# of weeks early or late _____) | _____ | _____ |
| Was birth: ☐ Vaginal ☐ C-section | | |
| Were there any problems with the baby at birth? | _____ | _____ |

If yes, please describe:

_____

Were there any problems with the baby in the nursery?

If yes, please describe:

_____

What was the birth weight _____lbs. _____ oz.

How many other children are in the family _____ Which number child is this?

_____

Who spends the most time with this child ☐ Mother ☐ Father ☐ Grandparent ☐ Childcare Provider

(fill in below)

Daytime: _____ Evening: _____ Overnight: _____