Parent/Child Health Questionnaire

Name of Parent _____

Address _____

_____

City/State/Zip _____

Phone # Work _____(Hours___ to ___)

Home _____

Name of Child _____

Address (if different from parent)

_____

_____

Phone # _____ Sex M F

Date of Birth _____Age _____

Who is responsible for your child's bill? ☐ You ☐ Spouse ☐ Auto Insurance
☐ Personal Health Insurance _____

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages?

_____

Was there back pain? _____

_____

Approximately how long was labor? _____

_____

Were you physically ill? (Colds, flu, allergies, German measles, anything like that) _____

If so, what? _____

Regarding Labor:

Was it chemically induced?	☐ Yes	☐ No
Doctor assisted?	☐ Yes	☐ No
Was C-Section performed?	☐ Yes	☐ No
Were forceps used?	☐ Yes	☐ No
Did doctor have hands on the infant?	☐ Yes	☐ No
Were you lying down?	☐ Yes	☐ No
Was family member present?	☐ Yes	☐ No

If yes, who? _____

(95% of all infants were born with hands on or forceps)

Was the baby premature? ☐ Yes ☐ No

If so, what was his/her age and weight? _____