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Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Pregnancy and Birth
   1. Did you have an illness during pregnancy? No Yes
   2. Did the baby come on time? Yes No
   3. What was the baby’s birth weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. Did your baby have any trouble starting to breathe? No Yes
   5. Did your baby have any trouble while in the hospital? No Yes
2. Feeding and Digestion
   1. Was there severe colic or any unusual feeding problems in the first 3 months? No Yes
   2. Is your child’s appetite usually good? Yes No
   3. Is it good now? Yes No
   4. Do any foods disagree with him/her? No Yes
   5. Does he/she often have diarrhea?

No Yes

* 1. Has constipation ever been much of a problem? No Yes

1. Family History
   1. Circle any of the following diseases that this child’s parents, grandparents, aunts, uncles, brothers, sisters have had: Tuberculosis, Diabetes, Asthma, Allergy, Seizures, Cancer, Mental Illness, Autism, Inherited Diseases.
   2. Are the child’s parents both in good health? Yes No
   3. List ages, sex and general health of siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. Have any of your children died? No Yes
2. Infections, Illnesses, Miscellaneous Problems and Development
   1. Has your child had as many as three bouts of ear trouble? No Yes
   2. Does he/she have any trouble with urination? No Yes
   3. Has he/she ever had a convulsion? No Yes
   4. Does he/she hear well? Yes No
   5. Has he/she ever had trouble with his/her eyes? No Yes
   6. At what age did he/she sit alone? \_\_\_\_\_\_\_\_\_\_\_
   7. At what age did he/she walk alone? \_\_\_\_\_\_\_\_\_\_\_
   8. Did he/she say any words by the time he/she was 1 ½ years old?

Yes No

* 1. Does he/she have trouble sleeping now? No Yes
  2. Are there any problems with his/her teeth? No Yes
  3. Circle any of the following that your child has had:

Pneumonia

Whooping cough

Serious accidents

Removal of tonsils and adenoids Surgical Operations\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Diseases? What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations? For what?\_\_\_\_\_\_\_\_\_\_\_

1. Allergies
   1. Has he/she ever had eczema or hives? No Yes
   2. Has he/she ever had wheezing or asthma? No Yes
   3. Does he/she tend to have a stuffy nose or “constant cold”? No Yes
   4. Has he/she had any allergies or reactions to any medicines or injections? No Yes
2. School/Emotional Problems
   1. Is he/she doing well in school?

Yes No

* 1. Any attention issues? No Yes
  2. Does he/she get along with other children? Yes No
  3. Underline any the following which your child has

nail biting thumb sucking

nightmares bad temper

irritable wets bed

won’t mind can’t toilet train

speech problems constipation