

**PEDIATRIC HEALTHCARE AND ASSOCIATES OF WAXAHACHIE**  
**Dr. Mary J Strength**

**DEVELOPMENTAL HISTORY**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please FILL OUT to best of your knowledge

**Pregnancy and newborn history:**

Did you carry your child for the full 9 months? If no, how long? \_\_\_\_\_

Child's birth weight \_\_\_\_\_ Birth Length \_\_\_\_\_ Inches \_\_\_\_\_

Medications during pregnancy \_\_\_\_\_

Problems during pregnancy:

Illness \_\_\_\_\_ Infections \_\_\_\_\_ Other \_\_\_\_\_

Labor: Length of labor \_\_\_\_\_ hours. Any difficulties? \_\_\_\_\_

Delivery: \_\_\_\_\_ Vaginal \_\_\_\_\_ C-section If C-section, why? \_\_\_\_\_

Any difficulties? \_\_\_\_\_

Did your child come home from the hospital with you? \_\_\_\_\_ Yes \_\_\_\_\_ No

Any special care needs in infancy? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Growth and developmental milestones:**

At what age did your child?

Sit \_\_\_\_\_ Say first words \_\_\_\_\_ Stand \_\_\_\_\_

Walk \_\_\_\_\_ Speak in sentences \_\_\_\_\_ Toilet train \_\_\_\_\_