**CHEMICAL STRESSORS**

Was the child breast-fed? ***Yes*** ***No*** ***If Yes***, how long? _____

At what age was formula introduced? _____ Which formula? _____

At what age was cow's milk introduced? _____

At what age did your child begin to eat solid foods? _____ Type of foods? _____

Food/Juice intolerance? ***Yes*** ***No*** Type? _____

During pregnancy, did the mother: smoke? ***Yes*** ***No*** How much? _____

use alcohol? ***Yes*** ***No*** How much? _____

use drugs? ***Yes*** ***No*** _____

During the pregnancy, did the mother suffer from any illnesses? ***Yes*** ***No***

_____

Were any supplements taken during the pregnancy? ***Yes*** ***No*** _____

Were any medications taken during the pregnancy? ***Yes*** ***No*** _____

Were any ultrasounds performed during the pregnancy? ***Yes*** ***No*** How many? _____

Please list the reason for the ultrasounds _____

Did the mother undergo any invasive procedure during the pregnancy (ie. amniocentesis, CVS, etc.)?

***Yes*** ***No*** ***If Yes***, please explain: _____

Are there any pets in your home? ***Yes*** ***No*** _____

Are any smokers living in the home? ***Yes*** ***No***

**VACCINATION HISTORY**

Vaccinations and age given: _____

Did the child ever have a negative reaction to a vaccination? ***Yes*** ***No***

***If Yes,*** please explain: _____

Has the child ever received antibiotics? ***Yes*** ***No***

For what reason? _____