

ABC Pediatrics, Ltd.
Infant Pediatric Health History Form—Initial Visit

Child's Name _____ Age _____
Your Name _____

Child's DOB _____ Today's date _____
Relationship to Child _____

Pregnancy and Birth

Maternal Exposures:

Medication? No Yes _____
Drugs/Alcohol? No Yes _____
Tobacco? No Yes _____
Infection/Grp B strep? No Yes _____

Birth problems for patient:

Jaundice? No Yes _____
Infection? No Yes _____
Breathing? No Yes _____
Low Blood Sugar? No Yes _____
Oxygen Use? No Yes _____
NICU stay? No Yes _____

Was your child premature? No Yes, born at _____ weeks
Delivery: vaginal c-section breech forceps
Where was your child born? _____
Is the child yours by birth adoption stepchild other
Birth weight _____ Length _____
Mother's blood type? _____
Other problems in the newborn period _____

Past Medical History of Your Infant

Any medications taken regularly? No Yes
Which ones? _____
Any allergic reactions to medications? No Yes
Which ones? _____
Any reactions to immunizations? No Yes
Which ones? _____
Any hospitalizations other than for birth? No Yes
For what? _____
Other history? No Yes
Which kind? _____

Safety / Environment

Is your water heater set to 120 degrees? Yes No
Is there a working smoke alarm on each floor in the house? Yes No
Does your child always use a car seat in the back seat when riding in the car? Yes No
Do you place your baby to sleep on his/her stomach? No Yes
Do you have help or support easily available? Yes No
Any stresses in the family? No Yes
Describe _____

Where does the baby sleep: _____ parents' room, _____ nursery
_____ sibling's room, _____ other?

Feeding and Nutrition

Any unusual feeding problems? No Yes
Breast or formula fed? _____
If on formula, which one? _____
Does he/she take vitamins? _____
If breastfeeding, how long do you plan to continue? _____

Review of systems

Any eye problems? No Yes
Difficult or noisy breathing? No Yes
Heart murmur or heart problem? No Yes
Problem with stools (diarrhea/constipation)? No Yes
Is he/she irritable or colicky? No Yes
Any skin conditions? No Yes
Problem with vomiting or excessive spit up? No Yes
Please list any other medical problems or explain above problems. _____

Social History

Who lives in the child's household? Mom Dad Step _____
 Siblings (# _____) Grandparents Other _____
Child's parents are married unmarried divorced other
Mom's Occupation _____ Dad's Occupation _____
Childcare parents relatives daycare babysitter/nanny
Days per week in childcare (not with parent) _____
Any pets? Yes No _____
Do any household members smoke? Yes No

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	-	-	-	-
Allergies	-	-	-	-
Anemia	-	-	-	-
Blood disorder	-	-	-	-
Cancer	-	-	-	-
Diabetes	-	-	-	-
High cholesterol	-	-	-	-
High blood pressure	-	-	-	-
Heart attack/disease	-	-	-	-
Thyroid Disease	-	-	-	-
Kidney disease	-	-	-	-
Seizures	-	-	-	-
Migraines	-	-	-	-
Autism	-	-	-	-
Depression/anxiety	-	-	-	-
Alcoholism	-	-	-	-
ADD/ADHD	-	-	-	-
Other issues	-	-	-	-

Please explain all positives. _____

Comments

