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
Is there a gun in the home? □ Yes □ No
Is it locked and separate from ammunition? □ Yes □ No

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Brother	Sister	Paternal Grandfather	PaternalGrandmother	Maternal Grandfather	Maternal Grandmothe
Asthma								
Allergies								
Anemia								
Blood Disorder								
Cancer								
High Cholesterol								
High blood pressure								
Heart attack/disease								
Diabetes								
Thyroid disease								
Seizures								
Migraines								
Autism								
Depression/anxiety								
Alcoholism								
ADD/ADHD								
Other issues								

Please explain all positives._____
_____