Infant Health History **0 to 12 months of age** Today's Date ____________

Child's Name ______________________________ Age ______ Date of Birth ____________ Sex : ☐ M ☐ F

Mother's Name ______________________________ Phone: Home (_____) ____________ Work (_____) ____________

Father's Name ______________________________ Phone: Home (_____) ____________ Work (_____) ____________

Home Address ____

Allergies

Substance	Reaction

Medications

Medication Name	Dosage

Pre-Natal History

During the pregnancy which conditions did you have? Please ☑ all that apply:

- ☐ Alcohol use
- ☐ Anemia
- ☐ Diabetes
- ☐ Edema
- ☐ Exposure to chemical or radiation
- ☐ Fever
- ☐ German Measles
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Protein in urine
- ☐ Tobacco use
- ☐ Urinary tract infection
- ☐ Venereal disease
- ☐ Other illnesses or infections ____________________________

- ☐ Drug use, non-prescription drugs (please list) ____________________________
- ☐ Drug use, prescription drugs (please list) ____________________________
- ☐ Drug use, controlled drugs such as narcotics (please list) ____________________________

Delivery

Place of Birth ____________________ Obstetrician ____________________ Mother's age at birth ________

Delivery Please check ☑ all that apply:

☐ On time ☐ Premature ☐ Late ☐ Normal ☐ Induced ☐ Prolonged ☐ Breech ☐ C-Section

Please describe ____

Infant Health and Problems

Birth weight ________________ Length ________________

Discharge weight ______________ Age when discharged ________

HEALTH PROBLEMS Please check ☑ and describe

- ☐ Birth Defects ____________________________
- ☐ Breathing Problems ____________________________
- ☐ Infection ____________________________
- ☐ Jaundice ____________________________
- ☐ Transfusion ____________________________
- ☐ Other ____________________________

Developmental

Please note age your child:

Lifted head	______ Wk.	Finger fed	______ Mo
Smiles	______ Wk.	Drank from cup	______ Mo
Rolled over	______ Mo.	Spoon fed	______ Mo.
Cooed / Laughed	______ Mo.	1st tooth eruption	______ Mo.
Babbles	______ Mo.	Says Mama and dada, used correctly	______ Mo.
Sits alone	______ Mo.		
Crawls	______ Mo.	Plays Peek a boo	______ Mo.
Stood up	______ Mo.	Walks no support	______ Mo.
Walked supported	______ Mo.	First Word	______ Mo.

Nutrition

Feeding ❒ Breast fed ❒ Formula fed

Please note age child was started on the following:

Cereals _______ Mo.

Vegetables _______ Mo.

Fruits _______ Mo.

Meats _______ Mo.

Solid Foods _______ Mo.

Is child's appetite good?	❒ Yes	❒ No
Does he/she take vitamins?	❒ Yes	❒ No
Any foods disagree with him/her?	❒ Yes	❒ No

If yes, Describe ____________________

Immunizations

Please check ☑ if started

Hepatitis B	❒ Yes	❒ No	DTaP	❒ Yes	❒ No
HIB	❒ Yes	❒ No	Polio	❒ Yes	❒ No
MMR	❒ Yes	❒ No	Chicken Pox	❒ Yes	❒ No
Prevnar(pneumococcal)	❒ Yes	❒ No			

Safety and Environment

Are there smokers in the household?	❒ Yes	❒ No
Are there working smoke detectors on each floor?	❒ Yes	❒ No
Does child always use car seat when riding in car?	❒ Yes	❒ No
Does child wear a helmet when bike riding?	❒ Yes	❒ No
Does child live in or visit homes built before 1960?	❒ Yes	❒ No
If yes, is there peeling or chipping paint?	❒ Yes	❒ No
Has your children or their friends had lead poisoning?	❒ Yes	❒No
Do you give your child home remedies with lead?	❒ Yes	❒ No
Does you child have access to drugs or chemicals?	❒ Yes	❒ No

Hospitalizations / Surgeries

Reason	Date	Hospital, City, State

Has your child ever had a blood transfusion? ❒ Yes ❒ No

Injuries / Illnesses

Serious Injuries/Illnesses	Date	Outcome

Family History

Check ☑ if the child's blood relatives had any of the following.

	Father	Mother	Siblings	Father's Parents	Mother's Parents
Alcoholism	❒	❒	❒	❒	❒
Allergies	❒	❒	❒	❒	❒
Anemia	❒	❒	❒	❒	❒
Arthritis	❒	❒	❒	❒	❒
Asthma/emphysema	❒	❒	❒	❒	❒
Birth defects	❒	❒	❒	❒	❒
Bone/joint disorders	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒
Epilepsy/Convulsions	❒	❒	❒	❒	❒
Eye or ear disorders	❒	❒	❒	❒	❒
Genetic defects	❒	❒	❒	❒	❒
Heart disease	❒	❒	❒	❒	❒
Hemophilia	❒	❒	❒	❒	❒
High blood pressure	❒	❒	❒	❒	❒
HIV/AIDS	❒	❒	❒	❒	❒

	Father	Mother	Siblings	Father's Parents	Mother's Parents
Kidney disease	❒	❒	❒	❒	❒
Loss of hearing, Blindness	❒	❒	❒	❒	❒
Lung disease	❒	❒	❒	❒	❒
Mental disease/disorder	❒	❒	❒	❒	❒
Mental retardation	❒	❒	❒	❒	❒
Migraines	❒	❒	❒	❒	❒
Muscle disorders	❒	❒	❒	❒	❒
Rheumatic fever	❒	❒	❒	❒	❒
Seizures/convulsions	❒	❒	❒	❒	❒
Sickle cell anemia	❒	❒	❒	❒	❒
Skin disease	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒
Thyroid disease	❒	❒	❒	❒	❒
Tuberculosis	❒	❒	❒	❒	❒
Venereal disease	❒	❒	❒	❒	❒
Other ____________	❒	❒	❒	❒	❒

Father's Age ________ General Health ____________________ Mother's Age ________ General Health ____________________

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my child's health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if my child ever has a change in health.

____________________ Signature of Parent, Guardian or Personal Representative

____________________ Date

____________________ Please print the name of Parent, Guardian or Personal Representative

____________________ Relationship to Patient

OFFICE USE ONLY

Reviewed by ____________________

Date ____________________