Premier Pediatrics of Palm Beach

Infant Health History Form – Initial Visit

Child's Name _____DOB _____ Age_____ Today's Date_____

Pregnancy and Birth

Maternal Exposures:

Medication ☐No ☐Yes_____

Drugs/Alcohol ☐No ☐Yes_____

Tobacco ☐No ☐Yes_____

Infection/Group B Strep ☐No ☐Yes_____

Birth History for Patient

Birth Weight_____

Delivery ☐vaginal ☐c-section ☐breech ☐forceps

☐Full-term ☐ Premature(if yes, born at _____weeks)

Jaundice ☐No ☐Yes_____

Infection ☐No ☐Yes_____

Breathing Problems ☐No ☐Yes _____

NICU stay? ☐No ☐Yes_____

At which hospital was your child born? _____

Is the child yours by ☐birth ☐adoption ☐stepchild ☐other

Any problems in the newborn period?

_____

_____

Past Medical History of the Patient

Any medications taken regularly? ☐No ☐Yes

Which ones? _____

Any allergic reactions to medications? ☐No ☐Yes

Which ones? _____

Any hospitalizations other than for birth? ☐No ☐Yes

If yes, please explain _____

_____

Other past medical history? ☐No ☐Yes

If yes, please explain _____

_____

Safety / Environment

Is your water heater set to 120 degrees? ☐No ☐Yes

Is there a working smoke alarm on each floor in the house? ☐No ☐Yes

Does your child always use a car seat? ☐No ☐Yes

Do you place your baby on his/her back to sleep ? ☐No ☐Yes

Do you have help or support easily available? ☐No ☐Yes

Any stresses in the family? ☐No ☐Yes

Please describe_____

_____

_____

Where does your baby sleep? ☐Parents room ☐Nursery ☐Siblings room ☐other_____

Feeding/Nutrition

Breast or formula fed? _____

If on formula, which one? _____

Any feeding problems? _____

Does he/she take vitamins? ☐No ☐Yes _____

Review of Systems

Any eye problems? ☐No ☐Yes_____

Difficulty or noisy breathing? ☐No ☐Yes_____

Heart Murmur/Heart Problem? ☐No ☐Yes_____

Diarrhea or constipation? ☐No ☐Yes_____

Is he/she irritable or colicky? ☐No ☐Yes_____

Any skin conditions? ☐No ☐Yes_____

Problems with vomiting or excessive spit up? ☐No ☐Yes

Please list any other medical problems or explain any problems mentioned above_____

_____

_____

Social History

Who lives in the child's household? ☐Mom ☐Dad ☐Step _____

☐Siblings (#____) ☐Grandparents ☐Other

Childs 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) _____

Do any household members smoke? ☐No ☐Yes

Family History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood Disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Heart attack/disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Autism	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
Other Issues:	☐	☐	☐	☐