

NB/Infant

Child's Name _____ Date of Birth _____ Today's Date _____

PreNatal/Birth History

Place of Birth _____ Gestational age _____
Birth Weight _____ Birth Length _____ Discharge Weight _____ Discharge Date _____
Delivery (circle one): Vaginal C-Section Feeding (circle all that apply): Breastfeeding Formula

Social History

Who lives at home _____
Number of Siblings _____
Smoking in the home _____
Pets _____
Guns in the home _____ If yes, are they kept locked and separate from the ammunition _____
City Water or Well Water _____

Family History

Check all that apply and list the family member(s) it pertains to

		Mother's Side	Father's Side
	Asthma		
	Heart Disease		
	Hypertension		
	Diabetes		
	Thyroid Disease		
	Cancer, Type		
	Mental Illness		
	Other:		
	Other:		