Parkway Pediatrics

Infant (<12mos) Pediatric Health History Form—Initial Visit

Child's Name _____ Age _____ Child's DOB _____ Today's date _____

Your Name _____ Relationship to Child _____

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:_____

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?

_____

Feeding and Nutrition

Any unusual feeding problems? ☐ No ☐ Yes

Breast or formula fed? Both?_____

If on formula, which one? _____

Does he/she take vitamins? _____

If breastfeeding, how long do you plan to continue?

_____

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Brother	Sister
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 _____

_____

_____

_____