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

Child's Name _____ Age _____

Child's DOB _____ Today's date _____

Your Name _____

Relationship to Child _____

Pregnancy and Birth

Maternal Exposures:
Medication? ☐ No ☐ Yes _____
Drugs/Alcohol? ☐ No ☐ Yes _____
Tobacco? ☐ No ☐ Yes _____
Infection/Grp B strep? ☐ ☐
☐ ☐

Birth problems for patient:
Jaundice? ☐ ☐ Yes _____
Infection? ☐ ☐ Yes _____
Breathing? ☐ ☐ Yes _____
Low Blood Sugar? ☐ ☐ Yes _____
Oxygen Use? ☐ ☐ Yes _____
NICU stay? ☐ ☐ 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? ☐ No ☐ Yes
Is there a working smoke alarm on each floor in the house? ☐ No ☐ Yes
Does your child always use a car seat in the back seat when riding in the car? ☐ No ☐ Yes
Do you place your baby to sleep on his/her stomach? ☐ No ☐ Yes
Do you have help or support easily available? ☐ No ☐ Yes
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? ☐ ☐
☐ ☐
☐ ☐

Pleaselist any othermedicalproblems orexplaintheabove 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? ☐No ☐Yes _____
Do any household members smoke? ☐ No ☐ Yes
Is there a gun in the home? ☐No ☐Yes
Is it locked and separate from ammunition? ☐No ☐Yes

Family History Do any family members have any of the following conditions:

Condition	Mother	Father	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
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 _____
_____