

Pediatric Health History Form – Under 3 Months

CHART #

Child's Name _____ Date of Birth _____ Age _____

Parent's Name _____ Parent's Name _____
 Male Female (please circle) Male Female (please circle)

Form filled out by _____ Date _____

Maternal/Obstetric History

Any concerns or abnormalities during pregnancy
 If yes, explain _____

Gestational Diabetes? Yes No
 PCOS? Yes No
 Thyroid Disease? Yes No
 Any previous perinatal depression? Yes No
 Other _____

Birth History

Pregnancy/Neonatal Period
 Where was your child born? _____

Is the child yours by birth adoption stepchild
 other

Delivery by Vaginal c-section
 Reason for c-section _____
 Complications _____

Was your child premature No Yes, born at _____ wks
 Complications _____

Did your child have phototherapy? Yes No
 Did your child have antibiotics? Yes No
 Did your child go to NICU? Yes No
 Did your child require oxygen? Yes No
 Birth weight _____ length _____
 Other problems in the newborn period _____

Breastfeeding History

Are you breastfeeding? Yes No
 If yes, Have you had any breast symptoms? _____

Any breast surgeries? _____

Have you breastfed previously? Yes No
 If yes, any difficulty Yes No
 Any supply issue? Yes No
 Did you supplement? Yes No
 Which formula? _____

Social History

Who lives in the child's household? Mom Dad Step _____
 Siblings (# _____) Grandparents Other _____

Mother's occupation _____
 Father's occupation _____

Child's parents are married unmarried divorced other

Will your child be going to Daycare? Yes No
 Where? _____

When? _____

Childcare other than Daycare
 parents relatives babysitter/nanny

Days per week in childcare (not with parents) _____

Do any household members smoke Yes No

Family History

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling	Grandparent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain all positives _____

Medications

Allergies to medication/vaccines (list and describe reaction)

Current Medications and dose: _____

Vitamins _____

Herbal supplements _____

Over-the-counter meds _____

Provider: _____ Date: _____