Katz Pediatrics

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/Grp B Strep ☐No ☐Yes_____

Birth Problems for patient:

Jaundice ☐No ☐Yes_____

Infection ☐No ☐Yes_____

Breathing Problems ☐No ☐Yes _____

NICU stay? ☐No ☐Yes_____

Was your child born premature? ☐No ☐Yes, born at _weeks

Delivery ☐vaginal ☐c-section ☐breech ☐forceps

Which hospital was your child born? _____

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

Birth Weight _____

Other problems in the newborn period?

_____

_____

Past Medical History of Your 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

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? ☐No ☐Yes

Do you place your baby on his/her back? ☐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 and Nutrition

Any feeding problems? ☐No ☐Yes

Breast or formula fed? _____

If on formula, which one? _____

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 the above problems? _____

_____

_____

Social History

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

☐Siblings (#____) ☐Grandparents ☐Other

Childs Parents are ☐married ☐unmarried ☐divorced ☐other

Moms Occupation_____ Dads 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:	☐	☐	☐	☐
_____	☐	☐	☐	☐

Please explain all positives_____

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