PEDIATRIC NEW PATIENT HEALTH HISTORY (0-2 YRS)

Please take a few minutes to answer these questions. We are asking these questions because the answers may help us provide better care for your baby and support for you.

Baby's Name: _____ DOB: _____
Name of person filling out form: _____
I am this baby's: ❑ Mother ❑ Father ❑ Grandparent ❑ Foster Parent ❑ Other: _____

Is your baby taking any medications, vitamins, or supplements regularly? ❑ No ❑ Yes If yes, what: _____
_____
Does your baby have any allergies (medicine, foods)? ❑ No ❑ Yes If yes, to what: _____
Has your baby been vaccinated? ❑ No ❑ Yes Where did your baby receive prior vaccinations? _____

MOTHER'S PREGNANCY & BABY'S BIRTH HISTORY

Did mother receive prenatal care? ❑ No ❑ Yes How many months pregnant when prenatal care began? _____

Did mother use any of the following during pregnancy (check if taken during any part of pregnancy)?

❑ Prescribed medications: _____ ❑ Tobacco ❑ Marijuana
❑ Over the counter medications: _____ ❑ Alcohol ❑ Other drugs

Were there any problems during pregnancy / labor / delivery? ❑ No ❑ Yes If yes, explain: _____
_____
Was baby born prematurely? ❑ No ❑ Yes Number of weeks pregnant at delivery? _____

Born at: ❑ Hospital-Name of hospital: _____ ❑ Home Delivery: ❑ Vaginal ❑ Cesarean
Place of Birth: City _____ State_____ Country _____
Birth weight: _____pounds_____ ounces Birth length: _____inches

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BABY'S HEALTH PROBLEMS (Check box if your baby has had any of these)

❑ Anemia	❑ Constipation	❑ Hearing Problem	❑ Seizures / Epilepsy
❑ Asthma	❑ Developmental delay	❑ Heart Problem/ Murmur	❑ Sickle Cell Disease
❑ Birth defect: _____	❑ Eczema	❑ Liver Problem	❑ Toothache / Decay
❑ Bleeding problem	❑ Eye / Vision Problem	❑ Kidney / Bladder Problem	❑ Tuberculosis
❑ Bone/joint/muscle problem	❑ Frequent ear infections	❑ Pneumonia	❑ Urinary tract infection (UTI)
❑ Chicken pox	❑ Other: _____		

Has your child been hospitalized or had surgery? ❑ No ❑ Yes When / why: _____
_____

FAMILY MEDICAL HISTORY (Check if your child's biological siblings, parents, or grandparents have had any of the following):

	Relationship to child		Relationship to child
❑ Alcohol/drug problem	_____	❑ Hepatitis	_____
❑ Anxiety	_____	❑ High Blood Pressure	_____
❑ Asthma	_____	❑ High Cholesterol	_____
❑ Autism	_____	❑ Intellectual disability	_____
❑ Birth defect	_____	❑ Kidney disease	_____
❑ Bleeding disorder	_____	❑ Mental illness	_____
❑ Cancer	_____	❑ Seasonal allergies	_____
❑ Childhood hearing loss	_____	❑ SIDS	_____
❑ Developmental delay	_____	❑ Stroke before age 50	_____
❑ Depression	_____	❑ Thyroid problem	_____
❑ Diabetes	_____	❑ Tuberculosis	_____
❑ Eczema	_____	❑ Other:	_____
❑ Epilepsy/ Seizures	_____	_____	_____
❑ Heart problem before age 55	_____	_____	_____

Signature: _____ Date: _____