INFANT HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Form completed by: **Date:**

Baby's Name: ☐ **M** ☐ **F** **DOB**
(Last, First, M.I.)

BIRTH HISTORY

Prenatal history:	☐ YES	☐ NO	Gestational diabetes
	☐ YES	☐ NO	Group B Strep
	☐ YES	☐ NO	Hypertension
	☐ YES	☐ NO	Smoking during pregnancy
	☐ YES	☐ NO	Alcohol or recreational drug use during pregnancy

Birth History: ☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐Vacuum ☐ Trauma?
Timing: ☐ On time ☐ Before 37 weeks of pregnancy ☐ After 42 weeks of pregnancy

Birth site: _____ Birth Attendant: _____

Illness: Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe

DIET AND ENVIRONMENT

Feeding Plans:

☐ Breastmilk only
☐ Formula
☐ Mixed

Home Environment:
How many children in your home? _____
This child's birth order (3rd of 4 kids…) _____
What adults live with your child? _____

☐ YES ☐ NO Does your home have adequate heat, a telephone and enough food?
☐ YES ☐ NO Was your home built before 1950?
☐ YES ☐ NO Does your home have mold?
☐ YES ☐ NO Is your home safe?

FAMILY HEALTH HISTORY

Is your child adopted? …….. ☐ Yes ☐ No
Have any family members had the following? If so, note relationship to child

☐ Yes ☐ No	Deafness	☐ Yes ☐ No	Bleeding disorder
☐ Yes ☐ No	Nasal Allergies/ Eczema or Asthma	☐ Yes ☐ No	Liver or Kidney disease
☐ Yes ☐ No	Developmental or genetic disorders	☐ Yes ☐ No	Diabetes before age 50
☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Bed-wetting after age 10
☐ Yes ☐ No	Heart Disease before age 50	☐ Yes ☐ No	Epilepsy or convulsions
☐ Yes ☐ No	High Blood Pressure before age 50	☐ Yes ☐ No	Alcohol or drug abuse
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Mental illness

What is your plan for vaccination? ☐ **CDC standard schedule** ☐**Alternative Schedule** ☐ **No vaccination**

Reviewed on _____ Physician Signature _____

ONE SKY FAMILY MEDICINE
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