CHART #

Pediatric Health History Form – **Under 3 Months**

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	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Migraines	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐
_____________	☐	☐	☐	☐

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:___________