

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	☐	☐	☐	☐
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: _____