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:_____