Tots 'N' Teens Pediatrics, P.C.
Infant Health History

Child'sName:_____Today'sDate:_____
SSN#_____Date of Birth:_____
Age:_____ Sex:_____ Race:_____

Pregnancy and Birth
Hospital of Birth:_____
Is this child yours by: birth adoption stepchild other _____
Delivery by: vaginal Csection(why?_____)
Birth Weight:_____ Length of Pregnancy:_____
Discharge Weight:_____ Discharge Date:_____
Problems during pregnancy (circle all that may apply):Diabetes High blood pressure
Rh problem Swelling Protein in urine Urinary tract infection
Breech Anemia Venereal Disease (gonorrhea, Chlamydia, Syphilis)
Other infection or illness:
Was there tobacco use during pregnancy? No Yes If yes, how much?_____
Was there alcohol or drug use during pregnancy? No Yes If yes, how much?_____
Medications taken during pregnancy:_____
Any medical problems in the newborn period?_____
_____

Feeding
Is your baby breastfed? Yes No
Is your baby formula fed? Yes No If yes, which brand?_____

Social History
Who lives at home? Do any of the household members smoke? Yes No

Name	Age	Relationship	Highest Education Level
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are the child's parents: Married Unmarried Separated Divorced
Parents' occupations: Mother_____ Father_____
Childcare: Parents Daycare Babysitter Other:_____
Is violence at home a concern? Yes No Are there guns at home? Yes No

The information that I have provided is, to the best of my knowledge, true.

Signature:_____

Relationship to patient:_____

Physician Signature and Date:_____