Infant Patient Questionnaire

For children from birth to age 12 months

**NAME:**

**DOB:**

**INTERPRETER NEEDED?**

<table>
<thead>
<tr>
<th>a. Medications/Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>List any allergy(ies) and reaction(s) child has had:</td>
</tr>
</tbody>
</table>

List any medications child is currently taking: NO

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dose</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
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</table>

Is child taking Vitamin D? NO YES

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<tr>
<th>b. Pregnancy/Birth History</th>
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<tbody>
<tr>
<td>Place of birth:</td>
</tr>
<tr>
<td>Mother received prenatal care:</td>
</tr>
</tbody>
</table>

**Problems during pregnancy:**

- Gestational Diabetes | NO | YES |
- Diabetes | NO | YES |
- Pre-eclampsia (pregnancy-induced high blood pressure) | NO | YES |
- Eclampsia (pregnancy-induced Seizures) | NO | YES |
- Other? | |

List mother’s medications during pregnancy: |

<table>
<thead>
<tr>
<th>List names of the patient’s siblings:</th>
<th>Birth Year</th>
</tr>
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</table>

**Labor and Delivery:**

- Type of Delivery: Vaginal C-Section
- Breech birth? NO YES
- Time of Birth: ___________
- Meconium? NO YES
- Delivered at Full Term Premature
- Gestational age at Birth: ___weeks___days
- Birth Weight: ___________
- Multiple births NO YES

**Discharge History:**

- Feeding History: Breast Bottle Both
- Discharge Date: _________
- Discharge Weight: _________

**At the Hospital, did child:**

- Receive Hepatitis B vaccine NO YES
- Hearing test PASS FAIL
- Have Jaundice? NO YES
- Require oxygen or ventilator support? NO YES
- Stay in intensive care nursery NO YES
- If yes, how long and why? _________________
- Birth defect NO YES
- If yes, what type? _________________
- Have newborn screen ("PKU test") NO YES
- Require any other treatment? NO YES
- If yes, what type? _________________

HealthPoint
c. Child’s Personal Health History

Has your child ever had or currently being treated for any of the following conditions?

- **Food allergies**
  - [NO] [YES]

- **Asthma**
  - [NO] [YES]

- **Breathing problems**
  - [NO] [YES]

- **Has child ever had a surgery?**
  - [NO] [YES]

- If yes, what type of surgery?

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**Heart problems**

- [NO] [YES]

**Hearing problems**

- [NO] [YES]

**Other:** ____________________________

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**Sudden death**

- [NO] [YES]

**Sickle cell disease**

- [NO] [YES]

**Bleeding disorder**

- [NO] [YES]

**Blood clots**

- [NO] [YES]

**ADD/ADHD**

- [NO] [YES]

**Asthma**

- [NO] [YES]

**Cancer**

- [NO] [YES]

**Deafness**

- [NO] [YES]

**Diabetes**

- [NO] [YES]

**High cholesterol**

- [NO] [YES]

**Strabismus/Lazy eye**

- [NO] [YES]

**Sudden death**

- [NO] [YES]

**Sickle cell disease**

- [NO] [YES]

**Bleeding disorder**

- [NO] [YES]

**Blood clots**

- [NO] [YES]

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1. Has any family member or relative died of heart problems or had unexplained or unexpected sudden death before the age of 50 (including drowning, unexplained car accidents, or sudden infant death syndrome)?

2. Does anyone in your family have a pacemaker, implanted defibrillator, or heart rhythm problem?

3. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

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d. Family History

- **Is the child adopted?**
  - [NO] [YES]

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**ADD/ADHD**

- [NO] [YES]

**Deafness**

- [NO] [YES]

**Sudden death**

- [NO] [YES]

---

**Asthma**

- [NO] [YES]

**Diabetes**

- [NO] [YES]

**Sickle cell disease**

- [NO] [YES]

---

**Cancer**

- [NO] [YES]

**High cholesterol**

- [NO] [YES]

**Bleeding disorder**

- [NO] [YES]

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**Strabismus/Lazy eye**

- [NO] [YES]

**Blood clots**

- [NO] [YES]

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**Has your child ever had or currently being treated for any of the following conditions?**

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**Heart problems**

- [NO] [YES]

**Hearing problems**

- [NO] [YES]

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Thanks for taking the time to tell us about your health history.