Infant Patient Questionnaire

For children from birth to age 12 months

NAME:

DOB:

INTERPRETER NEEDED?
☐ NO ☐ YES,_____

a. Medications/Allergies

List any **allergy(ies)** and **reaction(s)** child has had: ☐ NONE _____

_____

List any medications child is currently taking: ☐ NONE

Medicine:	Dose:	How often:	3.		
1.			4.		
2.			5.		

Is child taking Vitamin D? ☐ NO ☐ YES

B. Pregnancy/Birth History

Place of birth: _____

Mother received prenatal care: ☐ NO ☐ YES

Problems during pregnancy :

Gestational Diabetes ☐ NO ☐ YES

Diabetes ☐ NO ☐ YES

-If yes, did you require insulin? ☐ NO ☐ YES

Pre-eclampsia (pregnancy-induced high blood pressure) ☐ NO ☐ YES

Eclampsia (pregnancy-induced Seizures) ☐ NO ☐ YES

List names of the patient's siblings:	Birth Year

Other? _____

List mother's medications during pregnancy: _____ ☐ NONE

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? _____

_____

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	**Heart problems**	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Hearing problems	☐ NO ☐ YES
Breathing problems	☐ NO ☐ YES	Other: _____	
Has child ever had a surgery?	☐ NO ☐ YES	If yes, what type of surgery? _____	

d. Family History

Is the child adopted? ☐ NO ☐ YES

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
Heart Problems	☐ NO ☐ YES	Strabismus/Lazy eye	☐ NO ☐ YES	Blood clots	☐ NO ☐ YES

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)? ☐ NO ☐ YES
2. Does anyone in your family have a pacemaker, implanted defibrillator, or heart rhythm problem? ☐ NO ☐ YES
3. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ☐ NO ☐ YES

e. Social History

Does anyone living with this child smoke? ☐ NO ☐ YES Smoking/tobacco use allowed in the home? ☐ NO ☐ YES

Does child attend daycare? ☐ NO ☐ YES

Primary residence: ☐ Mother ☐ Father ☐ Other, _____ Secondary residence: ☐ Mother ☐ Father ☐ Other, _____

Mother's Name: _____ Birthdate: _____ Age:_____

Mother's occupation: _____

Father's Name: _____ Birthdate: _____ Age:_____

Father's Occupation: _____

Any concerns about relationships with family/friends/other? ☐ NO ☐ YES

Home type: ☐ Apartment ☐ House ☐ Condominium ☐ Mobile Home (trailer)

Does child drink tap water? ☐ NO ☐ YES

Does child ride in a car seat? ☐ NO ☐ SOMETIMES ☐ ALWAYS

Do you have the following at home:

Carbon monoxide detector ☐ NO ☐ YES

Smoke detector ☐ NO ☐ YES

Firearms ☐ NO ☐ YES

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

HealthPoint