

**Dr. Daniel A. Miller**  
**Infant Pediatric History Form**

Child's Name \_\_\_\_\_ Age \_\_\_\_\_

Your Name \_\_\_\_\_

**Pregnancy and Birth**

Maternal Exposures:

Medication?  No  Yes \_\_\_\_\_

Drugs/Alcohol?  No  Yes \_\_\_\_\_

Tobacco?  No  Yes \_\_\_\_\_

Infection Grp B Strep?  No  Yes \_\_\_\_\_

**Birth Problems for Patient**

Jaundice?  No  Yes \_\_\_\_\_

Infection?  No  Yes \_\_\_\_\_

Breathing?  No  Yes \_\_\_\_\_

Low Blood Sugar?  No  Yes \_\_\_\_\_

Oxygen Use?  No  Yes \_\_\_\_\_

NICU Stay?  No  Yes \_\_\_\_\_

Was your child premature?  No  Yes, born at \_\_\_\_\_ weeks

Delivery:  Vaginal  C-section  Breech  Forceps

Where was your child born? \_\_\_\_\_

Is the child yours by:  Birth  Adoption  Step-child  Other

Birth weight: \_\_\_\_\_ Length: \_\_\_\_\_

Mother's Blood Type: \_\_\_\_\_

Other problems in the Newborn period: \_\_\_\_\_

**Past Medical History of Your Infant**

Any medications taken regularly?  No  Yes

Which ones? \_\_\_\_\_

Any allergic reactions to Medications?  No  Yes

Which ones? \_\_\_\_\_

Any reactions to Immunizations?  No  Yes

Which ones? \_\_\_\_\_

Any hospitalizations other than for birth?  No  Yes

For What? \_\_\_\_\_

Other History?  No  Yes

What Kind? \_\_\_\_\_

**Safety and Environment**

Is your water heater set to 120 Degrees?  No  Yes

Is there a working smoke alarm

on each floor of the house?  No  Yes

Does your child always use a car seat

In the back seat when riding in a car?  No  Yes

Do you place your baby to sleep

On His/Her stomach?  No  Yes

Do you have help or support

easily available?  No  Yes

Any stresses in the family?  No  Yes

Describe \_\_\_\_\_

Where does the baby sleep?

Parent's Room  Nursery  Siblings Room  Other?

Child's DOB \_\_\_\_\_ Today's Date \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

**Feeding and Nutrition**

Any unusual feeding problems?  No  Yes

Breast or Formula fed? \_\_\_\_\_

If on Formula, Which One? \_\_\_\_\_

Does he/she take vitamins? \_\_\_\_\_

If Breastfeeding, how long do you plan to continue? \_\_\_\_\_

**Review of systems**

Any eye problems?  No  Yes

Difficulty or noisy breathing?  No  Yes

Heart murmur or heart problem?  No  Yes

Problem with stools (diarrhea/constipation)?  No  Yes

Is he/she irritable or colicky?  No  Yes

Any skin conditions?  No  Yes

Problem with vomiting or excessive spit-up?  No  Yes

Please list any other medical problems or explain above noted problems. \_\_\_\_\_

**Social History**

Who lives in the child's household?

Mom  Dad  Step-Parent  Siblings(# \_\_\_\_\_ )

Grandparents  Others \_\_\_\_\_

Child's parents are:  married  unmarried  divorced  other

Mom's Occupation \_\_\_\_\_ Dad's Occupation \_\_\_\_\_

Childcare?  parents  relatives  daycare  babysitter/nanny

Days per week in childcare(not with parent) \_\_\_\_\_

Any pets?  No  Yes \_\_\_\_\_

Do any household members smoke?  No  Yes

**Family History**

Do any family members have the following conditions.

Condition	Mother	Father	Sibling	Grandparent
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Asthma	___	___	___	___
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Allergies	___	___	___	___
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Anemia	___	___	___	___
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Blood Disorder	___	___	___	___
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Cancer	___	___	___	___
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Diabetes	___	___	___	___
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High Cholesterol	___	___	___	___
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High Blood Pressure	___	___	___	___
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Heart Attack/Disease	___	___	___	___
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Thyroid Disease	___	___	___	___
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Kidney Disease	___	___	___	___
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Seizures	___	___	___	___
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Migraines	___	___	___	___
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Autism	___	___	___	___
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Depression/anxiety	___	___	___	___
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Alcoholism	___	___	___	___
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ADD/ADHD	___	___	___	___
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Other Issues	___	___	___	___
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Please explain all positives \_\_\_\_\_

**Comments** \_\_\_\_\_

This is to certify that I have answered the questions on this form to the best of my knowledge. I understand that to provide incorrect information about my child's health and symptoms could place my child's health at risk

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Name of Parent or Guardian

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Signature of Parent/Guardian

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Date

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Signature of Reviewing Physician

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Date