

Birth to 24 Months

Birth Date: _____

Sex: _____

Race: _____

PRENATAL HISTORY (when child born)

1. Mother's age: _____
2. Father's age: _____
3. Marital status (circle one) M D S Sep.
4. Give the number of: Pregnancies _____
 live births _____ still births _____
 Miss/abor. _____
5. Order in family (order/total) _____
6. Prenatal care: Place _____
7. Month began _____ EDC _____
8. Gestation: _____ Diet: _____

BIRTH HISTORY

1. Place: _____
2. Length of labor (hours): _____
3. Type of delivery: Vag. _____ C-Sec. _____
4. Presentation: VTX _____ Breech _____
5. Health newborn: Yes _____ No _____
6. Apgar score: _____
7. Birth weight: lbs. _____ oz. _____
8. Birth length: _____
9. Discharge weight: _____ Date: _____
10. Breast or Formula fed (circle one)

1. Did you have any of the following illnesses during this pregnancy?

Type of illness	Yes	No	Comments
Anemia			
Bleeding			
Diabetes			
Hypertension			
Kidney Disease			
Rubella			
Drug abuse (type)			
Excessive weight gain (#30)			
Convulsions			
Smoking			
Alcohol			
Unusual illness or Fever			
Other			

2. What type of medication did you take during this pregnancy?

Medication	Yes	No	Comments
Vitamins			
Iron			
Tylenol			
ASA			
Other			

3. What diagnostic studies were done?

Diagnostic Studies	Yes	No	Comments
Sonograms			
X-Rays			
Dental X-Rays			
Amniocentesis			
Other			

4. Did your baby have any of these problems at birth?

Problem	Yes	No	Comments
Color			
Breathing			
Meconium Staining			
Deformity			
Feeding			
Infection			
Jaundice			
Other			

5. Did your baby have any of these problems during the first week of life?

Problem	Yes	No	Comments
Feeding			
Breathing			
Jaundice (Mx. Bili)			
Bili Lite (Duration)			
Infection			
Other			

6. SOCIAL HISTORY

1. No. of adults in the home: _____
2. Mother _____
3. Father _____
4. Extended Family (adults) _____
5. No. of children in the home _____
6. Siblings _____
7. Extended family (children) _____
8. Primary caretaker _____
9. Father employed? _____
10. Mother employed? _____
11. Financial Status _____
12. Welfare _____
13. Food Stamps _____
14. WIC _____
15. Pets _____

HOUSE

- Apartment _____
 House _____
 Farm _____
 Other _____
 # of bedrooms _____
 Where does child play? _____
 Bathroom facilities? _____
 City or well water (circle one)
 Does Pt need fluoride? Yes No
 Hot & cold water? _____
 Type of heat _____

Form completed by _____ P.N.P./M.D.

Date _____