Integrative Pediatric Health Care

Newborn Health History Form

Child's Name_____________________________ **Date of Birth**___________________________

Mother's Name ___________________________ **Parent 2 Name** ___________________________

Parent Concerns - Please explain any other concerns or questions you have about your child
____
____

Does your child take any medications / vitamins / over the counter supplements or herbs? Yes No
If yes please list below

_______________________________________ ____

_______________________________________ ____

Has your child received any immunizations? Yes NO If yes please provide an immunization record.

Social History

Please describe any spiritual or religious preferences____

Are there any objections or preferences to medical treatments (i.e prefer homeopathy, prefer not to immunize, etc.)?____

Please list all those living in the child's home.

____

____

Mother's occupation___________________________ Parent 2 occupation_____________________________

Childcare situation____

Prenatal and Infant Health History

Place of Birth___________________________________ Maternal age ____ Paternal age____
Birth weight ________________ Length ___________________ Head circumference ________________
Was the baby born at term? Yes OR ________ weeks
Were there any prenatal or neonatal complications? Yes No Explain_________________________
Was a NICU stay required? Yes No Explain____
During pregnancy, did mother
Use tobacco Yes No Drink alcohol Yes No
Use drugs or medications Yes No Use prenatal vitamins Yes No
Explain____
Was the delivery Vaginal Cesarean If cesarean, why? ____
List any medications, vitamins or supplements that Mom is currently taking _________________________
Infant feeding information- please provide the type, amount and frequency of infant feeding
Formula ____
Breast milk ____

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Family Medical History

Item	Yes	No	Don't know	Who	Comments
Childhood hearing loss					
Allergies					
Asthma					
Heart disease (before 55 years of age)					
High cholesterol					
Bleeding disorder					
Cancer (before 55 years of age)					
Liver disease					
Kidney disease					
Obesity					
Diabetes					
Developmental delay					
Seizures / neurological disorder					
Mental illness / depression					
Substance abuse					
Eating disorder					
Immune problems					
Additional family history					