THOUSAND OAKS PEDIATRICS
INTERIM HISTORY – INFANT (0 – 1)

Name _____ Date _____

- What concerns or questions about the baby do you have today? _____

  _____

  _____

- Has the baby had any significant illnesses or injuries since your last visit?

  _____

  _____

- What kind of developmental steps has the baby taken (i.e. rolling, sitting, crawling, babbling, etc.)? _____

  _____

  _____

- Is the baby sleeping through the night? _____

  How many times does the baby wake up during the night? _____

  How many times is the baby fed during the night? _____

- Who lives at home? _____
- Do you have any pets in the home? _____
- Does the baby take formula or breast milk? _____

  What type of formula? _____ How many ounces a day? _____

  If the baby has started solids, what kinds of things is the baby eating? _____

  _____

  Approximately how many wet diapers a day? _____

  How often does the baby stool? _____

- Does anyone smoke at your home? _____
- Is there a gun in your home? _____ Where and how is it stored?_____
- Is your house childproofed? Please circle the safety measures you have taken:

Gated the stairs; covered electrical outlets; adjusted your water heater to 125 degrees; locked up all medication/cleaning and cooking solutions; ALWAYS drive with baby in car seat