Dr. Tolga Icli
Infant Pediatric History Form

Child's Name _____Age _____
Your Name _____

Child's DOB _____ Today's Date _____
Relationship to Child: _____

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?

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
Asthma	__	__	__	__
Allergies	__	__	__	__
Anemia	__	__	__	__
Blood Disorder	__	__	__	__
Cancer	__	__	__	__
Diabetes	__	__	__	__
High Cholesterol	__	__	__	__
High Blood Pressure	__	__	__	__
Heart Attack/Disease	__	__	__	__
Thyroid Disease	__	__	__	__
Kidney Disease	__	__	__	__
Seizures	__	__	__	__
Migraines	__	__	__	__
Autism	__	__	__	__
Depression/anxiety	__	__	__	__
Alcoholism	__	__	__	__
ADD/ADHD	__	__	__	__
Other Issues	__	__	__	__

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

Name of Parent or Guardian	Signature of Parent/Guardian	Date

Signature of Reviewing Physician	Date