# INFANT HISTORY

## 2 months to 2 years

Today's Date _____

Patient's Name _____ Sex: M F Date of Birth _____ Age ___

The following questions are designed to help the doctor provide a detailed evaluation of your child.

**NUTRITION**

Yes No

☐ ☐ Is your child still being breast fed? If no, for how long was he/she breast fed _____

If still breast-feeding, how much cow's milk does the mother consume each day? _____

Yes No

☐ ☐ Is your child formula fed? Which formula or other milk source? _____

Yes No

☐ ☐ Is your child eating solid food? What foods does his/her diet contain? _____

_____ What is your child's favorite food? _____

Yes No

☐ ☐ Does your child have any feeding difficulties? _____

Yes No

☐ ☐ Does your child have any digestive disturbances? _____

Yes No

☐ ☐ Does your child have any food allergies? _____

Yes No

☐ ☐ Does your child have any persistent or intermittent skin rashes? _____

Yes No

☐ ☐ Is your child receiving any vitamin supplements? _____

**TRAUMA**

Yes No

☐ ☐ Has your child had any recent falls or trauma?

Describe the trauma and the date it occurred? _____

Yes No

☐ ☐ Has your child ever fallen down stairs or fallen from any height? _____

Yes No

☐ ☐ Has your child ever been in a motor vehicle collision or near-miss? _____

Yes No

☐ ☐ Has your child ever had a bone fracture or joint dislocation? _____

Yes No

☐ ☐ Has your child had any other trauma or injuries? _____

Yes No

☐ ☐ Does your child ever bang his/her head repeatedly against a wall, bed or other object?_____

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## 2 months to 2 years

### GROWTH AND DEVELOPMENT

Yes ☐ No ☐ Can your child sit unsupported? At what age did your child start to sit-up? _____ mths

Yes ☐ No ☐ Is your child crawling yet? At what age did your child start crawling? _____ mths

Yes ☐ No ☐ Is your child walking yet? At what age did your child start to walk? _____ mths

Yes ☐ No ☐ Does your child often trip and fall? _____

Yes ☐ No ☐ Does your have any other concerns about your child's growth and development? _____

### HEALTH HISTORY

Yes ☐ No ☐ Has your child had colic? _____

Yes ☐ No ☐ Has your child had any upper respiratory infections? How often? _____

Yes ☐ No ☐ Has your child had asthma? _____

Yes ☐ No ☐ Does your child ever complain of back or neck pain? _____

Yes ☐ No ☐ Does your child ever complain of pains in the arms or legs? _____

Yes ☐ No ☐ Does your child ever complain of headaches? _____

Yes ☐ No ☐ Has your child had any earaches ? At what age did the first earache occur _____

Yes ☐ No ☐ How frequently does your child have earaches? _____

Yes ☐ No ☐ Do your child's earaches usually tend to occur in the same ear? Is it right, left or both? ___

Yes ☐ No ☐ Has your child had any other illnesses?
Please list each illness and its approximate date _____

_____

Yes ☐ No ☐ Is your child presently receiving any medications ? _____

Yes ☐ No ☐ Has your child ever been to a hospital or emergency room for evaluation or treatment? _____

Yes ☐ No ☐ Has your child recently been vaccinated? _____

Yes ☐ No ☐ Do you have any other concerns about your child's health? _____