BABY CARE — PERSONAL & CONFIDENTIAL INFORMATION

DATE: _____ A.H.C.I.P.:

PATIENT NAME: _____ (_____)
nameof preference

Complete Address: _____

MOTHER'S Name:_____MOTHER'S Work Phone:_____

FATHER'S Name: _____FATHER'S Work Phone:_____

HOME Phone: _____ NUMBER OF SIBLINGS: Brothers _____ Sisters _____

1. BABY'S SEX: M ____ F _____ BIRTHDATE: _____ AGE: _____
2. BIRTH WEIGHT: _____ CURRENT WEIGHT: _____
3. BIRTH LENGTH: _____ CURRENT LENGTH: _____
4. Reason for Baby's Visit: _____
   -
   _____
5. BABY spends most of the WAKING HOURS with:

   (a) mother (b) father (c) grandparents (d) sitter (e) daycare

   (f) other _____
6. BABY is exposed to tobacco smoke on a daily basis: No ☒ Yes ☒

MOTHER'S CARE DURING PREGNANCY:

7. Cigarettes: (a) never smoked (b) no longer smoke (c) quit smoking during pregnancy

   (d) continue smoking regularly (if so, how much?)
8. Alcohol: **NONE** ☒ Yes ☒ if yes, how much? _____
9. Medication: **NONE** ☒ Yes ☒ if yes, how much? _____
10. Other Drugs: **NONE** ☒ Yes ☒ if yes, how much? _____
11. Mother's and/or Child's problems DURING Pregnancy: **NONE** ☒ Yes ☒

    if yes, please comment: _____
12. Was pregnancy full term? Yes ☒ No ☒ if no, when was the delivery? _____

The completion of this record allows for you and your baby to have an information base that is as important to YOU as it is to your doctor: please BE ACCURATE as much as possible in your answers!

13. PLACE OF BIRTH: (a) Home (b) Hospital (c) Birthing Center (d) Other _____
14. BIRTHING ASSISTED BY: (a) Obstetrician (b) G.P. (c) Midwife (d) Other _____
15. MANNER OF BIRTH: (a) Normal Vaginal (b) Forcep Assisted (c) Cesarean
16. LABOUR was: (a) average (b) easy (c) prolonged (d) extremely rapid
17. PROBLEMS encountered during LABOUR / DELIVERY? **NONE** ☒ Yes ☒ if yes, please comment:

18. Did the NEWBORN have ANY difficulty starting to breathe? No ☒ Yes ☒

19. Did the NEWBORN have JAUNDICE? No ☒ Yes ☒

20. Have you ever lost an infant to S.I.D., early stroke or other causes? No ☒ Yes ☒

21. **INFANT FEEDING:**

BREAST FED: No ☒ Yes ☒ if yes, how long? _____

FORMULA: Type _____

SOLIDS: When did you start? _____

ADDITIONAL SUPPLEMENTS: _____

22. Are there ANY PROBLEMS in the FEEDING SCHEDULE? No ☒ Yes ☒

23. History of COLIC: No ☒ Yes ☒ if yes, what time is the crying most intense?

_____

24. Number of hours of SLEEP per night: _____ Time put down for the night _____ p.m.

25. Quality of SLEEP: (a) Good (b) Fair (c) Poor (d) Restless (e) Fussy

26. Is the URINE STRAW COLORED? Yes ☒ No ☒

if no, explain: _____

27. Are BOWEL MOVEMENTS REGULAR? Yes ☒ No ☒

28. Are BOWEL MOVEMENTS of a yellowish color and toothpaste consistency? Yes ☒ No ☒

Comment: _____

29. Does your baby normally feel stiff on being picked up? No ☒ Yes ☒

30. Does your child have any history that may be considered unusual? No ☒ Yes ☒

31. Place a check mark beside ANY of the FOLLOWING that are a concern:

Recurrent eye infection ☒ Digestive problems ☒ Congested Breathing ☒

Recurrent ear infection ☒ Sluggishness ☒ Mouth Breathing ☒

Recurrent throat infection ☒ Restlessness ☒ Grasping Skills ☒

Eye focus skills ☒ Others _____

32. Are there HEREDITARY CONDITIONS in YOUR FAMILIES *(mother or father)* that <u>MAY</u> affect your BABY'S HEALTH? No ☒ Yes ☒ *if yes, please comment!*

_____

33. State approximate age when the following activity took place:

(a) sat up (unsupported) _____

(b) crawled – age _____

(c) stood – with support – _____ without support – _____

(d) walked – _____

34. Has the BABY had a: Please Circle appropriate letter and note age and problem:

(a) childhood disease: _____

(b) high fever: _____

(c) reaction to medication: _____

(d) reaction to immunization shots: _____

35. Name of Pediatrician and or G.P. _____

36. Date of LAST Visit to G.P. _____ Pediatrician: _____

PURPOSE: _____

37. Are you following an INFANT IMMUNIZATION PROGRAM: Yes ☒ No ☒

38. Has your INFANT been treated on an EMERGENCY BASIS: No ☒ Yes ☒

if yes, please comment: _____

39. Has a specialist other than a Pediatrician examined your baby? No ☒ Yes ☒

if yes, whom? _____