Pediatric Health Assessment for 0-2 years old

Name: ____________________________________ **Date of Birth:** ________________

Purpose for Contacting our Office: ____

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PRENATAL HISTORY:

Type of Birth: Hospital ________ Home _______ Birth Center ______Midwife______

Type of Delivery: Vaginal _________ Cesarean _________

Complications of Delivery: ____

Interventions: Forceps _________ Vacuum Extraction ________

Medications during delivery: ____

APGAR Score: At Birth _______________ After 5 minutes: _________________

FEEDING:

Breast Fed? ____________________ If yes, how long? ___________________________

Does he/she nurse equally on each breast?______________________________________

Allergies or Intolerances: ____

If formula fed, which formula? ____

Does baby frequently spit-up after feeding? ____________________________________

Does your child have any feeding issues? ______________________________________

Does your child have any persistent or intermittent skin rashes? ____________________

HEALTH HISTORY:

Preferred sleep position? ____

Preferred head position, especially in car seat? _________________________________

Does baby frequently arch his/her head and neck backward?_______________________

Crying/Irritability during diaper change? ______________________________________

Ever had a fever? ____

Ever hospitalized? ____

Any falls? ____

Any car accident or near-miss? ____

Any other trauma? ____

Does your child ever bang his/her head repeatedly on a bed, wall, etc.? _______________

Is child vaccinated? ____

Regular medications? ___________________________ Vitamins?__________________

Ear infections?___________If yes, when did they start?_________________More common in right or left ear?____

Asthma? ____

Any complaints of pain (head, back, arms, legs)? _________________________________

Any other health issue or illness (please list date of occurrence)_____________________

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DEVELOPMENTAL HISTORY: At what age did your child start to sit up? _______________

Cross Crawl? _____________ Stand Alone?_____________ Walk? ___________________

Do you have any other concerns about your child's health or development?

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