Cornerstone Family Practice **13-36 months** Health History Form

Name:_____
Date Today:_____Birth Date:_____
Age Today:_____

Who are the child's primary caregivers?_____
Siblings in household and ages?_____
Who cares for the child during the day?_____

Behavioral Problems?_____
_____

Nutrition: Is child eating baby foods? _____Table Foods?_____
Is child drinking cow's milk?_____Breastfeeding?_____
Is child eating a variety of foods?_____
Is child drinking from a cup?_____# of meals per day?_____
Is child taking a multivitamin?_____
Any feeding difficulties?_____

Sleeping: What type of bed does the child sleep in?_____
Where does the child sleep?_____
How many hours at a time will the child sleep?_____

Elimination: How many bowel movements per day?_____
How many times does the child urinate per day?(# of wet diapers)_____
Have you started or completed toilet training?_____

Safety: Are you using a car seat? Always_____Sometimes_____
Smoke detectors in your home?_____Any exposure to passive Cigarette Smoke?_____
Are their guns in your home?_____ Are they locked?_____
Is your home "child proofed"? How so? _____

Medical History: Does your child have any medical problems? Please list/describe
1._____
2._____
3._____

Immunizations: Is your child up-to-date as far as you know?_____
Any reactions to immunizations?_____

Allergies: Any allergies to medications/environmental factors/foods?_____
_____

Medications: Please list any medications your child is taking and dosages
1._____2._____
3._____4._____

Any concerns today?_____
_____