Cornerstone Family Practice Birth –12 months Health History Form

Name:_____
Date Today:_____ Birth Date:_____
Age Today: _____

Birth Weight_____ APGAR Scores ? 1min_____ 5min._____
Full Term Baby?_____
Born by Normal Vaginal Delivery ___ Cesarean Section_____
Any Problems with pregnancy or delivery?_____

Who are the primary caregivers?_____
Siblings in household and ages?_____
Are siblings helpful or feeling jealous of the baby?_____
Who cares for the baby during the day?_____

Nutrition: Breast feeding____ Bottle Feeding___ Formula Type?_____
Is Baby eating Rice Cereal?_____ Baby Foods?_____
Table foods?_____
Any Feeding Difficulties?_____
How many feedings per day?_____
How many ounces of formula or minutes spent on each breast per feeding?_____

Sleeping: How many times is baby awakening at night?_____
Where does the baby sleep?_____
How many hours at a time will the baby sleep for?_____
What position does the baby sleep in?_____

Crying: How would you classify the amount of crying your baby does?
Minimal___ Average___ Excessive___
What comforting techniques do you use?_____

Elimination: How many stools does baby have a day?_____
How many times does baby urinate (wet diapers) a day?_____

Safety: Car seat use Always___ Sometimes___
Smoke Detectors in your home? Yes___ No___
Is Baby exposed to passive cigarette smoke?_____
Is your house "baby proofed"?_____

Medical History: Does your baby have any medical problems? Please describe._____
_____
Immunizations: Any reactions to immunizations?_____
Allergies: Does your baby have any allergies that you know of?_____

Concerns today?_____