Best Kids Care

PRENATAL AND INFANT HEALTH HISTORY

Name: _____ Date:_____

Place of Birth:		O.B		Mom's age at birth	

During pregnancy, which of these conditions did you have? (Please check all that apply)

	Alcohol Use		German Measles		Venereal Disease
	Anemia		Hepatitis		Non-Prescription drug use:
	Diabetes		High Blood Pressure		Prescription drug use:
	Edema/Swelling		Protein in Urine		Controlled Substance drug use:
	Exposure to chemicals or radiation		Tobacco Use		Other:
	Fever		Urinary Tract Infection		

DELIVERY (Please circle all that apply): On Time Premature Late Normal Delivery Induced/Prolonged Breech C-Section

Please describe any other complications:										
Birth Weight		Lbs.		Oz.	Birth Defects;					
Discharge Weight		Lbs.		Oz.		Breathing Problems		Jaundice		Transfusion
Length at birth:					Feeding (circle one):					
Age at Discharge:					Breast		Formula		Both	

FAMILY HISTORY

Please circle any condition that any of the child's blood relatives have had and their relationship:

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Alcoholism		HIV/AIDS	
Allergies		Kidney Disorder	
Anemia		Lung Disorder	
Arthritis		Mental Disease/Disorder	
Asthma/Emphysema		Mental Retardation	
Birth Defects		Muscular Disorder	
Bone/Joint Disorders		Rheumatic Fever	
Cancer		Seizure/Convulsions	
Diabetes		Sickle Cell Disease	
Epilepsy		Skin Disease	
Eye/Ear Disorder		Stroke	
Genetic Defects		Thyroid Disorder	
Heart Disease		TB	
Hemophilia		Venereal Disease	
High Blood Pressure		Other?	

I acknowledge that the information contained herein is correct to the best of my knowledge.

Signature: Relationship to Patient: