Infant History Form

Background Information

Baby's Name: _____	Date of Birth: _____ Current age: _____
Baby's Address: _____	Parent/Caregiver Phone Number: _____
Parent/Caregiver Name: _____	Parent/Caregiver Email Address: _____
Baby's Primary Care Doctor: _____	Baby's Primary Care Doctor Phone Number: _____

Has your child been to his/her primary care doctor?

___ Yes	___ No. Please specify why not: _____

Have you seen any specialist, doctor or therapist for your baby's feeding difficulties?

___ No	___ Yes. Please specify: _____

Baby's Prenatal History

Is this your biological baby?

__ Yes	____ No. What is known about pregnancy history? _____

Were there any prenatal complications?

___ Polyhydraminos	___ Breech position	___ HELLP syndrome	___ IUGR
___ Cervical cerclage	___ Multiples. Please specify: _____		___ Preeclampsia
___ Atypical positioning	___ LGA	___ SGA	___ Gastroschisis
____ Other. Please specify: _____			

Were you (or your baby's birth mother) placed on bed rest?

___ No	___ Yes. At what month and for how long? _____

Did you (or your baby's birth mother) receive prenatal care?

__ Yes	____ No. Reason: _____

Did your baby move positions frequently in-utero?

__ Yes	____ No. What position did they stay in most of the time?_____

Was your baby exposed to controlled substances or alcohol in-utero?

__ No	____ Yes. Please specify: _____

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Additional information: _____
_____
_____
_____

Baby's Birth History

How many weeks gestation was your baby born? _____ Weeks

What was your baby's birth weight? _____ lbs, _____ oz

How was your baby delivered? (please check all that apply)

___Natural Delivery without Epidural	____ Natural Delivery with Epidural	___ Cesarean Section	___ Assisted delivery (forceps or vacuum)

Where was your baby's birth?

___ Hospital	___ Birthing center	___ Home	___ Other: _____

Were there any birth complications? (please check all the apply)

___ Jaundice	___ Intubation	___ Infection	___ Hypoxia
___ Nucal cord	___ Prolonged labor	___ Preeclampsia	___ Delivery assistance
___ Other: _____			

Did you (or the birth mother of your child) have any complications during the birth of your baby? (please check all the apply)

____ Hemorrhaging	___ Low blood pressure	___ High blood pressure
____ Other. Please specify: _____		

Additional information: _____
_____
_____
_____

Baby's Postnatal History

Did your baby spend time in the NICU?

___ No	___ Yes. Length of stay: _____ Treatments received: _____

What was your baby's length of stay in the hospital/birthing center after birth?

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___1 day	____ 2-3 days	___ 3-4 days	___ Other: _____

Was your baby able to be placed on the mother's chest for skin-to-skin contact immediately after birth?

___ Yes	___ No. Please specify why: _____

Did your baby have any problems after birth? (please check all that apply)

___ Fracture	____ RSV	___ Difficulty breathing	___ Other: _____

What was your baby's first feeding from?

___ Breast	____ Bottle	___ Tube	___ Other: _____

Additional information: _____

_____

_____

_____

Baby's Feeding History

How is your baby typically fed?

___ Bottle	____ Breast	___ Tube. Type: _____	___ Other: _____

Was breastfeeding attempted after birth?

___ Yes	___ No

Were there any complications with breastfeeding after birth?

___ No	___ Yes. Please specify: _____ _____ _____

Were there any complications with bottle feeding after birth?

___ No	___ Yes. Please specify: _____ _____ _____

Is your baby fed via tube?

___ No	___ Yes. Please specify: _____ _____ _____

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What is the average amount of feeds per day?

___ 8-10 times	____ 5-7 times	___ 4-6 times	___ On demand	___ Other: _____

What is the average length of feeds per day?

___ 5-10 minutes	____ 15-20 minutes	___ 30-45 minutes	___ Other: _____

What is the average amount your baby is consuming each feeding?

___ 1-2 ounces	____ 3-4 ounces	___ 5-6 ounces	___ Other: _____

Has your baby ever had a swallow study?

___ No	___ Yes. Please specify results: _____

Does your baby cough, sputter, or choke while feeding?

___ No	___ Yes. Please specify: _____

Does your baby use a pacifier?

___ Yes	___ No. Please specify why: _____

About how many wet diapers does your baby have in 24 hours?

___ 6 or more	____ 4-6	___ 2-4	___ 0-2	___ Not consistent

About how many dirty diapers does your baby have in 24 hours?

___ 3 or more	____ 2	___ 1	___ 0	___ Not consistent

What does your baby's stool typically look like?

___ Yellow/curds	____ Green/brown	___ Tary/Black	___ Bloody	___ Not consistent

Additional information: _____

_____

_____

_____

_____

Baby's Medical History

Has your baby ever been diagnosed with a medical condition, syndrome or disorder?

___ No	___ Yes. Please specify: _____

Does your baby currently have any of the following? (please check all that apply)

____ Acute infection	____ Nausea/vomiting	____ Staph infection	____ Tuberculosis

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____ Hemophilia	____ High blood pressure	____ Fractures	____ Inflammation
____ Diarrhea	____ Contagious skin disorder	____ Tracheostomy	____ Abdominal lump
____ Swollen joints	____ Distention of abdomen	____ Seizure disorder	____ Fever
____ Malignant cyst	____ Blood sugar disorder	____ Jaundice	____ Recent surgery
____ Vericose Veins	____ Broken or Dislocated bones	____ Hydrocephalus	____ Other: _____

Has your baby ever been diagnosed with tongue, lip or cheek ties?

___ No	___ Yes. Specify type(s): ____ Tongue ____ Lip ____ Cheeks (__ Right, __ Left)

Has your baby ever been treated for tongue, lip or cheek ties?

___ No	___ Yes. Method of release: ____ Scissors ____ Laser ____ Surgical with sutures

Has your baby been diagnosed or have any suspected structural differences?

___ Torticollis	___ Plagiocephaly	___ Other: _____

Does your baby have any known allergies (latex, medications, etc.)?

___ No	___ Yes. Please specify: _____

Does your baby have reflux?

___ No	___ Yes. Please time of day: _____

Is your baby up-to-date on his/her vaccinations?

___ Yes	___ No

Is your baby currently taking any medications?

___ No	___ Yes. Please specify type(s) of medication and what it is taken for: _____ _____

Did your baby pass his/her newborn hearing screening?

___ Yes	___ No. Follow up appointment date: _____

Does your baby have a history of ear infections?

_____ No	_____ Yes. Please specify frequency: _____

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Where does your baby sleep?

___ Crib/bassinet in baby's room	___ Crib/bassinet in parent's room	___ Co-sleeper on parent's bed
___ Parent's bed	____ Other. Please specify: _____	

How is your baby's sleep at night?

___ Good (sleeps through night)	___ Fair (sleeps for 4-5 hours at a time)	___ Poor (does not sleep for more than 4 hours)

How is your baby's sleep for naps?

___ Good (Takes 1.5-2 hour naps a few times per day)	___ Fair (Takes 1-1.5 hour naps a few times per day)	___ Poor (Takes short 30 minute naps a few times per day)

In what position does your baby sleep?

___ On his/her back	___ On his/her tummy	___ Other: _____

Do you have your baby on a schedule and/or routine?

___ No	___ Yes. Please specify: _____ _____

Is your baby colicky and/or hard to console?

___ No	___ Yes. Please specify: _____

Does anyone in your baby's household smoke?

___ No	___ Yes. Please specify who and where it's done: _____

How often does your baby get tummy time?

___1 time per day	____ 2-3 times per day	___ 3-4 times per day	___ None

Additional information: _____

_____

_____

_____

_____