Infant History Form

Background Information

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

Who does your baby live with? (please check all the apply)

___Mother	___Father	___Grandparent	___Twin Sibling	___Older Siblings	___Younger Siblings	___ Other: _____

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: _____

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: _____	

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

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Baby's Birth & Medical History

Is this your biological baby?

__ Yes	____ No. Age at adoption/foster: _____

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)

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

___ Jaundice	___ Intubation	___ Infection	___ Hypoxia	___ Preeclampsia
___ Other: _____				

Did your baby spend time in the NICU?

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

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	___ Preeclampsia
____ HELLP Syndrome	____ Other. Please specify: _____		

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

___Torticollis	____ RSV	___ Difficulty latching	___ Other: _____

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

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

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
____ Hemophilia	____ High blood pressure	____ Fractures	____ Inflammation

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____ 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	____ Feeding tube	____ Hydrocephalus

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

___ No	___ Yes. Please specify type: _____ How it was revised: ___ scissors ____ laser ____ surgically

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

Does your baby have a history of ear infections?

_____ No	_____ Yes. Please specify frequency: _____

Additional information about your baby's birth or medical history:

_____

_____

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Baby's Feeding History

How is your baby being fed currently?

___ **Breast Fed**	____ **Bottle**	____ **Tube fed**
Feeds per day: _____	Type of milk: _____	Reason: _____
Average length of feeding: _____	Feeds per day: _____	Feeds per day: _____
Is mother pumping? _____	Average length of feeding: _____	Type of feeds (continuous/ bolus): _____
Any complications: _____	Average OZ per feeding: _____	_____
_____	Any complications: _____	ML/OZ per bolus feeding: _____
_____	_____	Any complications: _____
____ **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

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 look like?

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

Additional information about your baby's feeding history:

_____

_____