INFANT

0-12 MONTHS

Child's Name: ________________________ AHC #: ________________________ Date: ________________

Address: ____ Home Phone #: ________________________

Mother's Name: ________________________ Work Phone # : ________________ Cell #: ________________

Father's Name: ________________________ Work Phone # : ________________ Cell #: ________________

Birth Date: D/ ___ M/ ___ Y/ ___ Age: ___ Sex: ❑ M ❑ F Weight: ________ Height: _________

Reason for Child's visit: ____

Health History

Labor and Delivery

1. Place of Birth: ____

   Birth Attendants: ____

2. Was there any difficulties with the labor and delivery? ❑ Yes ❑ No

   First stage (approx. time): __________ Any problems, drugs given, intervention: ___________________

   ____

   Second Stage (approx. time): ________ Problems, etc. ____

   ____

   Third Stage (appox. time): ___________ Problems, etc. ____

   ____

3. Baby's Apgar: 1 min. _______ 5 min. ___________

   Did the baby have any trouble starting to breathe? ❑ Yes ❑ No

   Baby's color at birth: ________________

   Did you get to hold the baby and keep the baby with you from the time of birth onward? _______________

   Was the baby given any medication or artificial feedings following the birth? ________________________

   Baby's weight at birth: ____________ Length: ________________

Newborn Period

1. Is your baby being breastfed? ❑ Yes ❑ No

   Any feeding problems? ❑ Yes ❑ No If yes, please describe: __________________________________

   Are any foods or liquids besides breast milk being given? _______________________________________

2. Any illnesses or problems since birth? ____

3. How would you describe your baby's disposition to this point? __________________________________

4. Any sleeping problems? ____

__________________________ __________________________ _____________

Parent's Printed Name | Parent's Signature | Date