French Broad Pediatrics
40 N Merrimon Ave. Suite 117
Asheville, NC 28805
Infant Pediatric Health History Form -Initial Visit

Child's Name_____
Your Name_____
Previous Physician/Specialist with dates and reason
_____
_____
Preferred Pharmacy_____
Reason for today's visit_____
_____
_____

Current Medications/Vitamins/Supplements
(name) (dose)
_____ _____
_____ _____
_____ _____

Allergies ☐ No Known ☐ **Yes**
(name and type of reaction)
_____
_____
_____
_____

Immunizations/Vaccines
Please list previous vaccines and most recent flu vaccine_____
_____
_____
Concerns regarding immunizations_____
_____
_____

Birth History
Group B Strep☐ No☐ **Yes**_____
Jaundice?☐ **No**☐ **Yes**_____
Infection?☐ No☐ **Yes**_____
Breathing?☐ No☐ Yes_____
Low Blood Sugar☐ No☐ Yes_____
Oxygen Use?☐ No☐Yes_____
NICU stay?☐ No☐ Yes_____
Was your child premature?☐ No☐Yes_____
_____
Delivery? ☐ vaginal ☐ c-section ☐ breech
Where was your child born?_____
_____
Birth weight?_____ Length_____
Other problems in the newborn period?_____
_____

Past Medical History
Infancy/Childhood/Adolescence
Has your child ever been treated or diagnosed with: (explain)
☐ Asthma or reactive airway disease_____
☐ Wheezing or bronchitis_____
☐ Recurring strep throat_____
☐ Seasonal Allergies_____
Eczema_____
☐ Pneumonia_____
☐ Urinary Tract Infections_____
☐Seizures_____
☐ Anemia_____
☐ Broken Bones_____
☐ Depression/Anxiety_____
☐ ADHD/ADD_____
☐ Heart Murmur_____
☐ Constipation_____
☐ Bedwetting/Incontinence_____
Other chronic medical conditions_____
_____
Has your child ever been hospitalized?☐ No ☐ Yes
(explain)_____
_____
Previous Surgeries and dates_____
_____

Family History (Mother, Father, Sibling, Grandparent)
Please list family members diagnosed with any chronic medical condition_____
_____
_____
_____
_____

Social History
Feeding and Nutrition
Any unusual feeding problems?☐ No☐ Yes_____
Breast or formula fed?_____
If on formula, which one?_____
Who lives in the child's home? ☐ Mom ☐ Dad
☐ Step-parent ☐ Siblings(#___)☐
Other_____
Child's parents are ☐ married ☐ unmarried
☐ divorced ☐ other_____
Childcare ☐ parents☐ daycare/after school
☐ babysitter/nanny
Any pets? ☐ no☐ yes How many ___type_____
_____
Do any household members smoke? ☐ No☐ Yes
Are their smoke detectors in the home?☐ No☐ Yes
Does your child use a seatbelt, car seat, carrier? ☐ No ☐ Yes
Are there guns present in the home? ☐ No☐Yes
Year in School_____
School Name_____
Does your child have fluoride in their drinking water?
☐ No ☐ Yes
Please review the topics listed below. Check if you any concern about your child:
☐ Physical Problem
☐ Vision
☐ Development
☐ Sleep Pattern
☐ Diet/Weight/Nutrition