

Kids & Teens Primary Healthcare, P.C.

Newborn/Toddler Questionnaire

Name of Obstetrician/Midwife: _____
Complications during Pregnancy? _____ N _____ Y, List: _____
Ultrasounds during Pregnancy? _____ N _____ Y, Number: _____
Medications during Pregnancy/Delivery? _____ N _____ Y, List: _____
Cigarette/Alcohol Use during Pregnancy: _____ N _____ Y
Location of Birth: _____ Hospital _____ Birthing Center _____ Home
Birth Intervention: ___ Forceps ___ Vacuum Extraction ___ Caesarian Section, Emergency or Planned?
Complications during Delivery? _____ N _____ Y, List: _____
Genetic Disorders or Disabilities: _____ N _____ Y, List: _____
Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

FEEDING HISTORY:

Breast Fed: _____ N _____ Y, How Long: _____
Formula Fed: _____ N _____ Y, How Long: _____ Type: _____
Introduced to Solids at: _____ Months, Cow's Milk at _____ Months
Food/ Juice Allergies or Intolerances: _____ N _____ Y
List _____

DEVELOPMENTAL HISTORY:

At what age was your child able to:
Respond to Sound Cross Crawl _____ Sit up _____ Stand Alone _____
Respond to Visual Stimuli _____ Hold Head Up Walk Alone _____
*According to the National Safety Council, approximately 50% of children fall head first from a high place their first year (i.e., a bed, changing table, down stairs, etc.) Was this the case with your child ___N ___Y
*Has Your Child Ever Been Involved in a Car Accident? _____N _____Y, List: _____
*Has Your Child Been Seen on an Emergency Basis? _____N _____Y, List: _____
*Other Traumas Not Described Above? _____N _____Y, List: _____
*Prior Surgery: _____N _____Y, List: _____

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____, being the parent or legal guardian of _____, voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures.

Guardian Signature

Date