INFANT DEVELOPMENTAL HISTORY

To be completed by the parent before admission

Child's Name: _____ Birthdate: _____

Health

- Does your child seem well most of the time? Yes No
- Is your child taking any medication at this time? Yes No
  (including aspirin, laxatives, vitamins, etc.)
  If yes, what? _____
  Why? _____
- Did your child have as many as three ear infections in the last year? Yes No
- Are you concerned about your child's hearing? Yes No
- In a year, does your child usually have more than three colds or sore throat infections with a fever? Yes No
- Are you concerned about your child's eyes or vision? Yes No
- Has your child been seen by a medical specialist? Yes No
  If yes, who? _____
  Why? _____
- What arrangements have you made if he or she becomes ill at the center? _____
- Does your child have any handicaps? Yes No
  If yes, describe: _____
- Does your child have any other illnesses or diseases? Yes No
  If yes, what? _____
- Has your child been hospitalized? Yes No
  If yes, why? _____
- Has your child had any serious accidents or poisonings? If yes, what? _____ Yes No
- Has your child had any of the following? Please circle:

  Premature birth birth injury head injury convulsions seizures

  trouble breathing at birth allergies (eczema, hives, drug, wheezing, food intolerance, asthma, insect stings)

  Describe: _____

  _____

  _____

- Are there any other special health needs that staff should be aware of about your child? If yes, please describe: _____ Yes No
  _____

Developmental & Family History

- How do you comfort your child? _____
- What are your child's favorite toys? _____
- What are your child's favorite activities? _____
- How does your family define your child's race?: _____

- What language is primarily spoken in your home?: _____
- What religion does your family define itself as?: _____

Sleeping

- Do you have any specific ways of helping your child go to sleep? _____

  _____
- Does your child cry when going to sleep? Yes No
- What is your child's sleeping schedule?
  - Night time: from _____ to _____
  - AM naps: from _____ to _____
  - PM naps: from _____ to _____
- Does your child need a pacifier? Yes No

Feeding

- Is your baby breast fed? Yes No Bottle fed? Yes No

  Type of bottle? _____ Type of nipple? _____

  Type of formula? _____

  How often does your baby need to be burped? _____
- What is your child's present eating schedule? (specify amount & time)

	Milk/Formula	Food
Breakfast	_____	_____
Snack	_____	_____
Lunch	_____	_____
Snack	_____	_____
- Does your child have any feeding problems? Yes No
  - If yes, what are they? _____
- Does your child have any special dietary needs? Yes No
  - If yes, please describe: _____

Toileting

- How frequently does your child have a bowel movement? _____
- Normal appearance of the B.M.: _____
- Does your child frequently have diaper rash? Yes No

  How is it treated? _____

Parent/Guardian Signature: _____ Date: _____