BABY CARE PATIENT FORM

DATE_____ A.H.C.I.P._____

PATIENT NAME: _____(_____)
name of preference

Complete Address: _____
postal code

MOTHER'S Name: _____ Mother's Work Phone _____

FATHER'S Name: _____ Father's Work Phone _____

HOME PHONE: _____ NUMBER OF SIBLINGS: Brothers _____ Sisters _____

1. BABY'S SEX: M ___ F ___ BIRTHDATE: _____ AGE: _____

2. BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

3. BIRTH LENGTH: _____ CURRENT LENGTH: _____

4. Reason for BABY'S visit:_____

_____

5. BABY spends most of the WAKING HOURS with:

a) mother b) father c) grandparents d) sitter e) daycare f) other _____

6. BABY is exposed to tobacco smoke on a daily basis. NO ___ YES ___

MOTHER'S CARE DURING PREGNANCY:

7. Cigarettes: (a) has never smoked (b) no longer smokes (c) quit smoking during pregnancy

(d) continued smoking regularly, (if so, how much?) _____

8. Alcohol: **NONE** ___ YES ___ if yes, how much? _____

9. Medication: **NONE** ___ YES ___ if yes, what type? _____

10. Other drugs: **NONE** ___ YES ___ if yes, what type? _____

11. Mother's and/or Child's problems DURING Pregnancy: **NONE**___ YES ___ if yes, please comment:

_____

12. Was Pregnancy Full Term: YES ___ NO ___ if no, when was the delivery?

_____

The completion of this record allows for you and your baby to have an information base that is as important to YOU as it is to your doctor: please BE ACCURATE, as possible in your answers!

13. Place of birth: (a) Home (b) Hospital (c) Birthing Center (d) Other _____

14. Birthing Assisted by: (a) Obstetrician (b) G.P. (c) Midwife (d) Other _____

15. Manner of BIRTH: (a) Normal Vaginal (b) Forcep Assisted (c) Cesarean

16. LABOUR was: (a) Average (b) easy (c) prolonged (d) extremely rapid

17. PROBLEMS encountered during LABOUR / DELIVERY? NONE ___ YES ___ if yes,

please comment: _____

18. Did the NEW BORN have ANY difficulty starting to breath? NO ___ YES ___

19. Did the NEW BORN have JAUNDICE: NO ___ YES ___

20. **INFANT FEEDING:**

BREAST FED: NO ___ YES ___ if yes, how long? _____

FORMULA: Type _____

SOLIDS: When did you start? _____

ADDITIONAL SUPPLEMENTS: _____

21. Are there ANY PROBLEMS in the FEEDING SCHEDULE: NO ___ YES ___

22. History of COLIC: NO ___ YES ___ if yes, what time is the crying most intense?

_____

23. Number of hours of SLEEP per night: _____ Time put down for the night _____p.m.

24. Quality of SLEEP: (a) Good (b) Fair (c) Poor (d) Restless (e) Fussy

25. Is the URINE STRAW COLORED: YES ___ NO ___ if no, explain: _____

26. Are BOWEL MOVEMENTS REGULAR: YES ___ NO ___

27. ARE BOWEL MOVEMENTS OF A YELLOWISH COLOR AND TOOTHPASTE CONSISTENCY:

YES___ NO___ Comment: _____

28. Place a check mark beside ANY of the FOLLOWING that are a concern:

Recurrent eye infection ___ Digestive problems ___ Congested Breathing ___

Recurrent ear infection ___ Sluggishness ___ Mouth Breathing ___

Recurrent throat infection ___ Restlessness ___ Grasping Skills ___

Eye focus skills ___ Others _____

PATIENT NAME: _____ Date _____

28. Does your baby normally feel stiff on being picked up? NO ___ YES ___

29. Does your child have any history that may be considered unusual? NO ___ YES ___

Comment? _____

30. Are there HEREDITARY CONDITIONS in YOUR FAMILIES *(mother or father)* THAT MAY effect YOUR BABY'S HEALTH? NO ___ YES ___ *if yes, please comment!*

_____

31. State approximate age when the following activity took place.

(a) sat up (unsupported) - age _____

(b) crawled - age _____

(c) stood - with support - age _____ without support - age _____

(d) walked - age _____

32. Has the BABY had a: Please Circle appropriate letter and note age and problem.

(a) childhood disease: _____

(b) high fever: _____

(c) reaction to medication: _____

(d) reaction to immunization shots: _____

33. Name of Pediatrician and or G.P. _____

34. Date of LAST Visit to G.P. _____ Pediatrician: _____

PURPOSE: _____

35. Are you following an INFANT IMMUNIZATION PROGRAM: YES___ NO___

36. Has your INFANT been treated on an EMERGENCY BASIS: NO___ YES ___ If yes, please comment: _____

37. Has your baby been examined by a specialist other than a Pediatrician? NO ___ YES ___

If yes, by whom? _____

38. Have you ever lost an infant to S.I.D., early stroke or other causes? NO ___ YES ___

Thank you for completing this form, this is the end! The next side is to be completed by your Doctor who will be with YOU as quickly as possible.

DOCTOR'S INTERVIEW

EXAMINATION