0–1-YEAR-OLD NEW PATIENT INTAKE FORM

Name of Person Completing Form: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Allergies: _____

Medications: _____

_____

Concerns Today: _____

PATIENT BIRTH HISTORY

Birth Weight: _____ Birth Length: _____ Gestational Weeks: _____

Birth Hospital: _____ Type of Delivery: □ Vaginal □ C-Section

Baby went to: □ Well Baby Nursery □NICU Hospital Length of Stay: _____

Passed Newborn Hearing Screen: □ No □ Yes

Received Vitamin K: □ No □ Yes

Received Hep B Immunization: □ No □ Yes

Any of the following complications during or after delivery:

□ Jaundice (yellowing of the skin)
□ Blood sugar problems
□ Drug withdrawal
□ Forceps delivery
□ Breathing problems/ need for oxygen
□ Birth defects
□ Other, list: _____

PREGNANCY HISTORY

Mother's Age at Delivery: _____

Mother Substance Use with Pregnancy: □ None □ Alcohol □ Tobacco □ Marijuana □ Narcotics

Prescription Medications (during pregnancy and if breastfed): _____

_____

Complications during pregnancy or labor such as:

□ Preeclampsia
□ Gestational diabetes
□ Moderate to severe illness/infections
□ High blood pressure
□ High risk pregnancy
□ Anemia
□ Other, list: _____

*Please complete back side

PATIENT PAST MEDICAL HISTORY

Medical History: _____

_____

Surgical History: _____

Therapies: □ No □ Yes, list: _____

PATIENT NUTRITION

□ Formula: _____ □ Breastfed □ Expressed Breast Milk □ Baby foods/solids

Amount: _____ Frequency: _____

Vitamin D supplement: □ Yes □ No Other vitamins or supplements: _____

PATIENT SOCIAL HISTORY

Patient lives with: □ Biological Mother □ Biological Father □ Sibling(s) □ Step-mother □ Step-father

□ Foster Care □ Other: _____

If two separate households, the parenting time share is: _____

Do you have stable housing: □ Yes □ No

History of Abuse/ Trauma: □ No □ Yes (□ Physical □ Verbal □ Sexual □ Domestic Violence Exposure)

Guns in the home □ Yes (□ Secured □ Unsecured) □ No

Secondhand Smoke Exposure □ Yes (□ In home □ In car □ Outside) □ None

Car Safety: □ Rear Facing Car Seat □ Forward Facing Car Seat □ Booster Seat □ None

Where does baby sleep: _____

FAMILY HISTORY

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Asthma	□	□		High Cholesterol	□	□	
Autism	□	□		High Blood Pressure	□	□	
ADHD	□	□		Genetic Disorder	□	□	
Congenital Heart Disease	□	□		Seizures	□	□	
Diabetes	□	□		Cancer	□	□	
Eczema	□	□		Bleeding Disorder	□	□	
Drug/Alcohol Abuse	□	□		Depression/Anxiety	□	□	
Heart problems	□	□		Other Mental Health	□	□	
Thyroid	□	□		Other	□	□	