Medical Information Intake Form – 0 to 36 Months

Name: _____ Birth Date: _____

****PLEASE ATTACH CURRENT IMMUNIZATION RECORD****

Parents' Marital Status: _____ Lives with: _____

Primary Caregiver during the day: _____

____ Brothers _____Sisters Birth Order: _____

Smokers at home:_____

Diet: Breast Milk Bottle Other: _____

Birth History: (Circle all that apply)

Vaginal C-Section (Why C-Section):_____

Term Pre-Term (How many weeks along?):_____

Prenatal Complications: Gestational Diabetes Pre-Eclampsia Other: _____

Medical Problems/Significant Hospital Stays	Year	Previous Surgeries	Year
1. _____	____	1. _____	_____
2. _____	____	2. _____	_____
3. _____	____	3. _____	_____

Family Medical History (i.e. heart attack, stroke, diabetes, colon cancer)

Mother: _____ Father: _____

Sibling(s): _____

Other: _____

Medications:

Name	Strength	Directions as noted on bottle
1.		
2.		
3.		
4.		

Allergies to medication	reaction
1. _____	_____
2. _____	_____

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