MARY ANNE MORELLI HASKELL, D.O.

A Professional Corporation

1224 Tenth Street, Suite 207 • Coronado, Ca. 92118
Phone: (619) 437-6600 • Fax: (866) 868-5194

INFANT NEW PATIENT FORM - Birth to 1 year

Patient's Name: _____ Date of 1st Appointment: _____

Age: _____ Date of Birth: _____ Gender: ❒ Male ❒ Female

Mother's Full Name: _____

Father's Full Name: _____

Parents Relationship Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other
Living Situation: ❒ Parents ❒ Father ❒ Mother ❒ Guardians ❒ Other: _____

Who may we thank for referring you to our office? _____

HOW MAY WE SUPPORT YOU AND THE HEALTH OF YOUR CHILD?

_____

_____

_____

PRENATAL HISTORY

Mother's age at child's birth: _____What number pregnancy was this birth? _____
Number of miscarriages _____ Number of abortions: _____ Number of live births: _____
Was pregnancy: ❒ Planned ❒ Unplanned ❒ In-Vitro ❒ Artificial Insemination ❒ Amniocentesis
Number of ultrasounds: _____ Illnesses during pregnancy: _____
Were you happy to be pregnant? ❒ Yes ❒ No • Are you in a supported relationship? ❒ Yes ❒ No
Medications during pregnancy, including Rhogam: _____

Vaccines during pregnancy: ❒ Yes ❒ No
If yes, which and what trimester: _____

Please check any of the following you had during this pregnancy:
❒ Bleeding ❒ Nausea ❒ Illnesses ❒ Hypertension ❒ Swelling ❒ Diabetes ❒ Thyroid Issues ❒ Physical or Emotional Issues ❒ Cigarettes ❒ Alcohol ❒ Drugs
❒ Other: _____

BIRTH HISTORY

Term Length: ❒ Full ❒ Late by _____ / days ❒ Premature ❒ Early by _____ / days
Birth Weight: _____ Birth Length: _____ Length of Labor: _____/____ hours/minutes
APGARs: One (1) minute: _____ Five (5) minute: _____
Birth was located at: ❒ Home ❒ Birth Center ❒ Hospital

How was the baby's appearance? _____

Please check the following complications that may apply:
❒ Pitocin ❒ Epidural or Spinal Anesthesia ❒ C-Section ❒ Forceps ❒ Episiotomy ❒ Vacuum Extraction ❒ Cord Wrapped Around Neck ❒ Meconium Staining ❒ Birth Defects ❒ Birth Injuries ❒ Blue Baby ❒ Cerebral Palsy ❒ Seizures ❒ Jaundice ❒ Colic ❒ Fever ❒ Rashes ❒ Unusual Cry ❒ Head Uneven ❒ Breast Fed Immediately ❒ Difficulty Latching

INFANT'S DIET HISTORY

Did you breastfeed? ❒ Yes ❒ No
If yes, how long? _____ Hours between feedings? _____
Please check all that apply: ❒ Breast surgery ❒ Hormonal issues ❒ Diet contains adequate amounts protein, healthy fat and fluids? ❒ Sore nipples ❒ Does baby prefer one breast over the other
Any difficulties? If so, please explain: _____

Formula used, if any: ❒ Cow /Dairy ❒ Goat ❒ Soy
❒ Other: _____ Ounces per feeding: _____

Does baby react to any foods you eat? If so, please explain: _____
_____
Age when solids were introduced: _____ List first foods: _____

Any food intolerances? _____

Any known allergies/sensitivities to:

❒ Drugs (penicillin, etc.):_____

❒ Foods (gluten, casein, etc.):_____

❒ Environmental (smoke, pollen, animal, etc.): _____

❒ Chemicals (perfumes, etc.): _____

INFANT'S CURRENT DIET (And Mother's diet if child is still nursing)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: _____

Cravings/Intolerances: _____

SLEEP PATTERNS / DEVELOPMENT

Age when started to;

Sleep through the night: _____ Sit up: _____ Belly crawl: _____

Creep on hands/knees: _____ Cruise: _____Walk: _____ Talk: _____

Did your child use a: ❒ Swing ❒ Walker

Describe any developmental concerns?

_____

HEALTH ISSUES/SYMPTOMS: Please "check" with a (C) for Current or a (P) for Past

❒Rigidly Arches Backwards ❒Too Loose or Floppy Muscle Tone ❒Too Tight or Rigid Muscle Tone ❒Torticollis (Head and Neck Side-bent) ❒Helmet Used for Uneven Head ❒Difficulty Wearing Certain Clothing

❒Cries Easily ❒Unusual Fears ❒Sleep Issues ❒/Nightmares ❒Nervousness

❒Skin Rash ❒Hives ❒Baby Acne ❒Eczema ❒Easy Bruising ❒Diaper Rash ❒Jaundice

❒Vomiting ❒Difficulty Feeding ❒Constipation/GI ❒Diarrhea ❒Gas ❒Colic ❒Stomach Aches

❒Hearing Loss ❒Dizzy Spells ❒Excessive Fatigue ❒Light Sensitivity ❒Noise Sensitivity

❒Wheezing ❒Coughing ❒Nose Bleeds ❒Frequent Colds ❒Ear Infections ❒Asthma ❒ Motion Sickness ❒High Fevers

❒Anemia ❒Heart Murmur ❒Congenital Heart Issues

FAMILY HISTORY:

Mother's Health: _____

Father's Health: _____

Sibling's Health: _____

Please list any major diseases/illnesses that run in the family genetics with any Grandparents, Aunts, or Uncles, i.e.; diabetes, cancer, heart disease, addictions, mental illness, etc.:

_____

_____

_____

ACCIDENTS/INJURIES: (brief description)

Date Accident/Injury Diagnosis Doctor:

_____

HOSPITALIZATIONS OR SURGERIES: (brief description)

Date Hospital Diagnosis/Surgery Doctor:

_____

Has your child had any of the following tests?

Hearing Evaluation Date: _____Where: _____

Results: _____

Vision Date: _____Where: _____

Results: _____

IMMUNIZATIONS: (check all that apply)

❒DTaP ❒HIB ❒Pneumococcal or Prevnar ❒Polio ❒Hepatitis B ❒Rotoviras ❒Influenza ❒ MMR List any additional immunizations:

_____

Adverse Reactions? (Describe severity, length of time and age of reaction)

_____

List any medications: Name / What's it for? / For how long? / Strength - Dose – Frequency
Please note if medications are current (c) or past (p)

_____

Name of Doctor's Office/Hospital/Clinic where your infant's health records are kept:

_____