Infant Health History Form

PATIENT INFORMATION

Patient's Name:

First Name: _____ Last Name: _____

Birth Date (MM/DD/YYYY): _____ **Sex** (M/F): _____

Birth Hospital: _____ **Birth Weight:** _____

Present Weight: _____ **Vaginal Birth?** Yes No **C-Section Birth?** Yes No

Any Birth Complications? Yes No **If Yes, please explain:** _____

MEDICAL HISTORY

Infants are usually given Vitamin K at birth to prevent bleeding in the first 8 weeks of life.
Did your child receive the Vitamin K shot? Yes No

Was your infant premature? Yes No **If Yes, how many weeks?** _____

Does your infant have heart disease? Yes No **If Yes, please explain:** _____

Has your infant had any surgery? Yes No **If Yes, please explain:** _____

Are you presently breastfeeding? Yes No **If no, how long since you stopped?** _____

Bleeding Disorder? Yes No **If Yes, please explain:** _____

Has your infant experienced any of the following? Please check and elaborate as needed.

Poor latch at breast at bottle? Yes No **If Yes, please explain:** _____

Falls asleep while eating? Yes No **If Yes, please explain:** _____

Slides off the nipple when attempting to latch? Yes No **If Yes, please explain:** _____

Colic Symptoms? Yes No **If Yes, please explain:** _____

Reflux Symptoms? Yes No **If Yes, please explain:** _____

Clicking or smacking noises when eating? Yes No **If Yes, please explain:** _____

Gagging or choking when eating? Yes No **If Yes, please explain:** _____

Gassy(toots a lot)/Fussy often? Yes No **If Yes, please explain:** _____

Poor weight gain? Yes No **If Yes, please explain:** _____

Gumming or chewing your nipple when nursing? Yes No

If Yes, please explain: _____

Pacifier falls out easily, or after a few minutes? Yes No **If Yes, please explain:** _____

Milk dribbles out of mouth when nursing/bottle? Yes No **If Yes, please explain:** _____

Short sleeping requiring feedings every 1-2 hours? Yes No **If Yes, please explain:** _____

Snoring, noisy breathing or mouth breathing? Yes No **If Yes, please explain:** _____

Feels like a full time job just to feed baby? Yes No **If Yes, please explain:** _____

Nose congested often? Yes No **If Yes, please explain:** _____

Baby is frustrated at the breast or bottle? Yes No **If Yes, please explain:** _____

Spits up often? Yes No **If Yes, please explain:** _____

Is your infant taking any medications? Yes No **If Yes, please explain:** _____

Has your infant had a prior surgery to correct the tongue or lip tie? Yes No
If Yes, please explain: _____

How long does it take baby to eat? _____

How often does baby eat? _____

Do you have any of the following signs or symptoms? Please check and elaborate as needed:

Creased, flattened or blanched nipples? Yes No **Lipstick shaped nipples?** Yes No

Plugged ducts/engorgement/mastitis? Yes No **Infected nipples or breasts?** Yes No

Blistered or cut nipples? Yes No **Nipple thrush?** Yes No **Bleeding nipples?** Yes No

Poor or incomplete breast drainage? Yes No **Using a nipple shield?** Yes No

One side hurts worse? Yes No **If Yes, please explain:** _____

Pain when first latching (1-10): _____ **Pain during nursing (1-10):** _____

PEDIATRICIAN INFORMATION

Pediatrician: _____

Phone Number: _____

Lactation Consultant: _____

Phone Number: _____

Who referred you to our office: _____

RESPONSIBLE PARTY (PARENT/GUARDIAN)

Parent/Guardian Full Name:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____ **Social Security:** _____

Address:

Street Address: _____

Street Address Line 2: _____

City: _____ State/Province: _____ Postal/Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Business Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

Parent/Guardian Full Name:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____ **Social Security:** _____

Address:

Street Address: _____

Street Address Line 2: _____

City: _____ State/Province: _____ Postal/Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Business Phone: _____ **Email:** _____

Employer: _____ **Occupation:** _____

Is patient living with both parents/guardians? Yes No

Siblings:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY)**:** _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: _____ **Group No. :** _____

Insurance ID Number: _____ **Policy Holder Name:** _____

Secondary Dental Insurance: _____ **Group No. :** _____

Insurance ID Number: _____ **Policy Holder Name:** _____

CONSENT FOR TREATMENT

☐ **I am the (parent/guardian) of the child listed above who is a minor child, and I authorize examination and treatment as necessary by or under the supervision of Growing Smiles. This includes exposure of radiographs as necessary, use of local anesthesia, inhalation and oral medication, responsible restraint as needed, and use of appropriate medicaments and materials for such treatment. If I have any objections to certain aspects of treatment. I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.**

Signature of Parent/Guardian: _____

Date: _____