

Cornerstone Family Practice **13-36 months** Health History Form

Name: _____
Date Today: _____ Birth Date: _____
Age Today: _____

Who are the child's primary caregivers? _____
Siblings in household and ages? _____
Who cares for the child during the day? _____

Behavioral Problems? _____

Nutrition: Is child eating baby foods? _____ Table Foods? _____
Is child drinking cow's milk? _____ Breastfeeding? _____
Is child eating a variety of foods? _____
Is child drinking from a cup? _____ # of meals per day? _____
Is child taking a multivitamin? _____
Any feeding difficulties? _____

Sleeping: What type of bed does the child sleep in? _____
Where does the child sleep? _____
How many hours at a time will the child sleep? _____

Elimination: How many bowel movements per day? _____
How many times does the child urinate per day? (# of wet diapers) _____
Have you started or completed toilet training? _____

Safety: Are you using a car seat? Always _____ Sometimes _____
Smoke detectors in your home? _____ Any exposure to passive Cigarette Smoke? _____
Are their guns in your home? _____ Are they locked? _____
Is your home "child proofed"? How so? _____

Medical History: Does your child have any medical problems? Please list/describe
1. _____
2. _____
3. _____

Immunizations: Is your child up-to-date as far as you know? _____
Any reactions to immunizations? _____

Allergies: Any allergies to medications/environmental factors/foods? _____

Medications: Please list any medications your child is taking and dosages
1. _____ 2. _____
3. _____ 4. _____

Any concerns today? _____
