# Infant Developmental/Health History

Infant's Full Name_____ Nickname_____

Date of Birth _____

Gender: ❒ Male ❒ Female

Gender

## Health History

Does your infant seem well most of the time? ❒ Yes ❒ No

Is your infant taking any medications now? ❒ Yes ❒ No

If yes, please list and explain for what purpose:

In a year, has your infant had 3 or more ear infections? ❒ Yes ❒ No

In a year, does your infant usually have more than 3 colds or sore throat infections with a fever?

❒ Yes ❒ No

Has your infant been seen by a medical specialist? ❒ Yes ❒ No

If yes, for what reason?

What arrangements have you made for the care of your infant should he/she become ill while in child care?

Does your infant have any health-related or other needs that you would like us to be aware of?

❒ Yes ❒ No

If yes, please list:

Does your infant have any contagious illnesses that could impact other children or staff? ❒ Yes ❒ No

If yes, please provide details:

Has your infant ever been hospitalized? ❒ Yes ❒ No

If yes, please provide details:

Has your infant had any serious accidents or poisonings? ❒ Yes ❒ No

If yes, please provide details:

Does your infant chew unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster, or hair? ❒ Yes ❒ No

If yes, please provide details:

Is your infant allergic to anything? ❒ Yes ❒ No

If yes, please list and note what symptoms your infant exhibits when having an allergic reaction:

## Developmental History

How do you comfort your infant?

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| What are your infant's favorite toys? |
| What are your infant's favorite activities? |
| What language(s) is/are spoken in your home? |

## Sleeping

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| Please list any specific ways you help your infant go to sleep |
| Does your infant cry when going to sleep? ❒ Yes ❒ No |
| What is your infant's current sleeping schedule?<br>Nighttime:<br>Morning nap:<br>Afternoon nap:<br>Other (list): |
| At naptime, does your child use (check all that apply): ❒ pacifier ❒ stuffed animal/toy ❒ blanket |

## Feeding

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| Is your infant breast-fed? ❒ Yes ❒ No Formula fed? ❒ Yes ❒ No |
| If your infant is formula fed, what type of formula do you use? |
| What type of bottle and nipple does your infant prefer? |
| Does your infant need to be burped? ❒ Yes ❒ No |
| Does your infant eat baby food? ❒ Yes ❒ No<br>If yes, please list any particular likes or dislikes: |
| Does your infant eat table food? ❒ Yes ❒ No<br>If yes, what types of food has he/she been fed thus far: |
| What is your infant's current eating schedule? (please specify times and amounts)<br>Nighttime:<br>Morning:<br>Afternoon:<br>Snacktime: |
| Please list any special feeding concerns we should be aware of: |

## Toileting

How frequently does your infant have a bowel movement?

Please describe typical appearance of bowel movement:

Does your infant often get a diaper rash? ❒ Yes ❒ No

If yes, how do you treat it?