Infant Development History

Child's Name_____

Developmental:

1. Do you have any concerns about your baby's hearing? Yes No Have they had any ear infections? Yes No
2. Do you have any concerns about your baby's eyes or vision? Yes No
3. Has your baby been hospitalized? Yes No
   If you circled yes to any of the above, please describe:

4. Has your baby had any of the following? Premature Birth Trouble breathing at birth Birth injury or defect
   Head injury Allergies (eczema, hives, drug, food intolerance, wheezing, asthma, insect stings)
   If you circled yes to any of the above, please describe:

Developmental:

1. How do you comfort your baby? _____
2. What are your baby's favorite toys? _____
3. What are your baby's favorite activities? _____
4. Is there a second language spoken in your home? _____

Sleeping:

1. Do you have any specific ways of helping your baby go to sleep? _____
2. Does your baby cry when going to sleep? Yes No
3. What is your baby's current sleep schedule?
   Nighttime From _____ To _____
   AM Nap From _____ To _____
   PM Nap From _____ To _____
4. Does your baby prefer to sleep on his/her: Stomach Side Back
5. Does your baby use a pacifier at naptime? Yes No

Feeding:

1. Is your baby breast fed? Yes No
2. Is your baby bottle fed? Yes No
   If yes, Type of: Bottle _____ Nipple _____ Formula _____
3. Does your baby drink from a sippy cup? Yes No
4. What is your baby's current eating schedule? (Specify time, ounces, and substance)

   Breakfast _____ _____ _____
   Lunch _____ _____ _____
   Snack _____ _____ _____

5. Does your baby have any feeding concerns? Yes No
   If yes, what are they? _____

Toileting:

1. How frequently does your baby have a bowel movement? _____
2. Appearance of typical bowel movement? _____
3. Does your baby have diaper rash often? Yes No
   How is it treated? _____