Minor Questionnaire/ Additional Information:

Name: _____ DOB/Age: _____/____ Date: _____

Male [ ] Female [ ]

Pediatrician? [ ] _____ Nurse Practioner [ ] _____

Provider's phone number: _____ Fax#: _____

Labor and delivery details: Induced **Y N** Pitocin **Y N** Other Inducing agent **Y N** Epidural **Y N**

C-section/Cesarean section **Y N** Vacuum/Forceps **Y N**

Other details: _____twin, preterm or less than 37 weeks, etc.

Birth medications: Hepatitis B vaccine **Y N** Vitamin K shot? **Y N**

During delivery any antibiotics or medications given to mom? **No Yes**; If Yes What type:

_____

Child's Medications: **None Yes**; If Yes: Prescription [ ] Over the Counter (OTC) [ ]: please list if can remember

_____

Child's Supplements: **None Yes**; If Yes: brand or name (feel free to list on separate sheet if necessary)

_____

Breast fed? Never No Yes; If Yes Exclusively? **Y N** How long? _____

Formula fed? Never No Yes; If Yes Brand (s):_____

Child's Vaccination? Never [ ] No [ ] Yes [ ] Modified schedule [ ]: explain _____

_____

Child's Food Sensitivities? None Noted Yes: _____

Child's Chemical Sensitivities? None Note Yes: _____

Child's Procedures: Circumcision? **Y N** If Yes: When? _____ Who? _____

Lip Tie: **N Y** If Yes corrected: When? _____ Who? _____

Tongue Tie: **N Y** If Yes corrected: When? _____ Who? _____

Home Remedies that have been tried for this? _____

Mother's Blood Type? **O A B AB Unknown** Father's Blood Type? **O A B AB Unknown**

Any Siblings with same/similar complaints? No Yes Other:_____

Is there anything else you would like us to know? _____

Parent/Guardian Signature: _____ **Date:** _____