

Infant and Toddler Health History (Continued)

Section C: Sleeping History (Continued)

- 5. Does your child need a pacifier to fall asleep?.....  Yes  No
- 6. Does your child need a blanket to fall asleep?.....  Yes  No
- 7. Does your child need a toy to fall asleep?.....  Yes  No

Section D: Feeding History

- 1. Is the baby breast-fed?.....  Yes  No
- 2. Is the baby bottle fed?.....  Yes  No
- 3. Type of bottle? \_\_\_\_\_
- 4. Type of formula? \_\_\_\_\_
- 5. How many ounces taken between burps? \_\_\_\_\_
- 6. What is your child's present eating schedule? (Specify amount and time for milk, formula, juice, food, etc.)  
Breakfast: \_\_\_\_\_  
A.M. Supplements: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
P.M. Supplements: \_\_\_\_\_
- 7. Has your child had any feeding problems? .....  Yes  No  
What? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Section E: Toileting History

- 1. How frequently does your child have a bowel movement (B.M.)? \_\_\_\_\_
- 2. Appearance of B.M. \_\_\_\_\_
- 3. Is your child toilet trained?.....  Yes  No
- 4. What word does your child use for urination? \_\_\_\_\_
- 5. What word does your child use for B.M.? \_\_\_\_\_
- 6. Does he/she use a potty chair? .....  Yes  No
- 7. Does your child frequently have diaper rash? \_\_\_\_\_
- 8. How do you treat your child's diaper rash? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Parent's Signature**

\_\_\_\_\_  
**Date**

**Additional Information**

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