

YOUR BABY'S HEALTH HISTORY

Baby's Full Name:		Date of Birth:	
Birth Weight:	Birth Length:	Head Circumference:	
Current Weight:	Current Length:	Full-term:	Pre-term:
Current Doctor:	Doctor's release signed:	Date:	
Any problems or abnormalities:			
INFANT ILLNESSES			
Date:		Recovered:	
Symptoms:			
Doctor called?			
Diagnosis:			
Instructions:			
Medications given:			How Long?
Side effects:			
IMMUNIZATIONS			
	Date:	Reactions:	
DTP			
Boosters			
Polio			
MMR			
Hepatitis			
Other			
ALLERGIES			
List:			
FEEDING SCHEDULE			
Breast-fed:		Bottle-fed:	
Length of Time:	Frequency at Breast:	Amount:	Frequency:
	Every _____ hours		Every _____ hours
Solid Food:			
Age :	Type:	Amount:	Times:
SLEEP SCHEDULE			
Wake-up Time:		Morning Nap Time:	
Afternoon Nap time:		Bedtime:	
Night time Routine:			