



507-451-7580
507-451-5387

admin@drdarrenowatonna.com
www.Bridgeshealthclinic.com
215 18th St. SE Owatonna, MN 55060

Baby/Toddler Questionnaire (Birth – 2 Years)

Today's Date: _____

Child's Name: _____ Date of Birth: _____

Birth was via (please circle): Vaginal C-section Emergency C-Section

How long was active labor (6+cm dilation) (please circle)? Short (<3hrs) Common (4-8hrs) Long (>8hrs)

How long was Pushing Labor? _____ Born at how many weeks Gestation: _____

Was the labor induced (please circle)? Yes No During pregnancy, I had _____ # of ultrasounds

During pregnancy or labor I had (please circle)? +IV Fluids +Pitocin +Cytotec +Breech Birth

+Membranes Stripped +Epidural +Anesthesia +Directed Pushing

+Use of Forceps +Use of Vacuum +Other: _____

Baby/Toddler is (please circle): +strictly breastfed +strictly formula fed +breast & formula fed +Baby cereal

+Using Bottles +Using Pacifiers If formula fed, what formula? _____

Is/Was there any difficulty breastfeeding (please circle)? Yes No

I am worried about my baby's/toddler's weight (please circle)? Yes No

I am worried about my baby's/toddler's growth (please circle)? Yes No

Approximately how many wet diapers/day for baby/toddler? _____

Approximately how many bowel movements/day for baby/toddler? _____

Approximately how many hours is baby/toddler sleeping? _____ Mom? _____

Has baby/toddler received recommended vaccinations (please circle)? Yes- all Yes- some No-none

My baby/toddler is mostly (please circle): +Happy +Crying +Sleeping +Content

+Hungry +Other: _____

Has your baby/toddler had any difficulty with (please circle)? +Spit-up/Vomiting +Sleeping +Crying

+Breastfeeding +Weight Gain +Ear Infections +Constipation +Diarrhea

+Teething +Other: _____

Is your baby/toddler taking any medications or supplements? _____

Surgical/Illness History: _____

Any other concerns about baby/toddler? _____

This form was completed by: _____ Relation to child: _____

Signature: _____ Date: _____