

NEWBORN HISTORY

Patient's Name _____ DOB _____
(If patient is greater than two years of age, skip to side 2)

Please fill in or check off each item.
 This information will help us provide your child with quality medical care.

NEWBORN HISTORY (Full-term = 40 weeks)

How many weeks? _____
 Birthweight _____
 Hepatitis shot at hospital? yes no
 Which pregnancy was this for mom? _____
 How many living children? _____
 Mom's age at babies birth? _____

BABY'S DELIVERY

Vaginal _____
 C-Section _____
 Induced _____
 Spontaneous _____

	Yes	No	Not Sure
Did the baby have any problems at birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time in intensive care nursery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice, high bilirubin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need bili-lights?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there any complications with the pregnancy, labor, delivery or birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please fill in if you had the following during your pregnancy with this child:

	1ST 3 MONTHS	2ND 3 MONTHS	3RD 3 MONTHS
INFECTIONS - Cold, Flu - Chlamydia, Gonorrhea, etc. - Bladder Infections			
MEDICATIONS (Other than vitamins)			
ACCIDENTS OR INJURIES - Did anyone hurt you?			
SMOKING - How many packs/day			
ALCOHOL (Includes beer, wine, other) - Include type of alcohol - How often you drank - Amounts you drank - Include amounts during time you did not know you were pregnant			
DRUGS - Include type - How often			

Patient's Name _____ DOB _____

FAMILY HISTORY

Check off if mother, father, sibling, or any close blood relative of the child has or has had the following:

	Yes	No	Relationship to Child
Convulsions, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies, Hay Fever.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease (heart attack/strokes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Disorder/Depression, Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/Bowel Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision/Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol and/or Drug Use.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/Joint Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

Is the child adopted? Yes No Do you know any of the child's family history? Yes No

LIVING SITUATION

How many people live in your household? _____ # of Adults _____ # of Children _____

Names and ages _____

Parents marital status: Married Divorced Separated Single Other _____

If divorced, separated or single parent - is the other parent involved Yes No

Does child live regularly in another household? Yes No If yes, describe _____

PREVIOUS ILLNESSES FOR YOUR CHILD (Has your child had any of the following)

Trauma/Fractures _____

Chronic or recurrent problems with Ear Infections Asthma/Wheezing Bladder Infections

Other _____

Is your child enrolled in special service for: Speech Behavior Learning

Any hospitalizations? Yes No If yes, age _____, illness _____

Any Surgeries? Yes No If yes, age _____, type of surgery _____

Any Allergies? Yes No If yes, describe _____

REVIEWED _____