Newborn Information and Medical History (Updated 12/2016)

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Child's Full Name_____ **Date of Birth**_____

Address_____ **City**_____ **State**_____
Zip Code_____ **Phone Number**_____**Alternate Phone Number**_____

Mother's Name_____ **Father's Name**_____
Mother's Occupation_____ **Father's Occupation**_____
Does mother live with Child? [ ] Yes [ ] No **Does father live with child?** [ ] Yes [ ] No

Legal Guardian Name_____ **Siblings Names/Birthdates:** _____
Is the child adopted? [ ] Yes [ ] No _____
Is the child in foster care? [ ] Yes [ ] No _____
_____

Mother's age at birth_____ **Father's age at birth**_____
Birth Hospital_____
Type of delivery [ ] Vaginal [ ] C-section
Birth weight_____lbs _____oz **Weight on day of discharge**_____lbs _____oz
APGAR scores if known_____ 1 min _____ 5 mins
Number of day's baby stayed in the hospital after birth_____
Do you feel sad or depressed since the birth of the baby? [ ] Yes [ ] No [ ] Not sure [ ] I'm not the birth mother

Birth History	**Yes**	**Please give details**
Was baby born early?		How many weeks?
Did baby need any help breathing after delivery?		
Did/does the baby have jaundice(yellow skin)?		
Did baby spend any time in Newborn Intensive Care(NICU)?		
Were forceps or vacuum used to deliver baby?		
Was a heart murmur present at delivery?		
Does baby have any unusual birthmarks or skin tags?		
Does baby have any conditions diagnosed *before* birth?		
Was baby born outside of tradition hospital? (home, birthing center, car, etc.)		
Did baby receive the first hepatitis B vaccine?		
Did baby pass the hearing screen in the hospital?		

Pregnancy History

While pregnant with *this* child did the mother	**Yes**	**When**	**Explain (include dates if known)**
Drink alcohol/beer?			
Smoke cigarettes?			
Use illicit drugs? (marijuana, cocaine, etc.)			
Take medications other than vitamins?			
Have diabetes?			
Test positive for Group B strep?			
Have any other illnesses or disease?			
Have any contractions?			
Have prescribed bed rest?			
Suffer physical or emotional abuse?			
Have any other complications?			

Parent or Guardian Signature_____ **Today's Date**_____

Family History (This should include grandparents, aunts, uncles, etc. Please indicate which relative by illness)

[ ] ADD / ADHD _____
[ ] Alcoholism/Drug Abuse _____
[ ] Allergies-nasal;Environmental,Food _____
[ ] Arthritis _____
[ ] Asthma/RAD _____
[ ] Autoimmune Disorder-Lupus,Psoriasis _____
[ ] Blood Disorder-Hemophilia,Sickle Cell, Bleeding Problems _____
[ ] Bed Wetting _____
[ ] Cancer _____
[ ] Complications from Anesthesia _____
[ ] Congenital Birth Defects _____
[ ] Congenital Heart Disease-VSD, Tetrology, Single Ventricle _____
[ ] Developmental Delay/Disorder-Austim, Speech Delay _____
[ ] Diabetes- Onset under 25 yrs _____
[ ] Down's Syndrome _____
[ ] Ear Problems-Cholesteotoma, Frequent Ear Infections _____
[ ] Eczema _____
[ ] Epilepsy/Seizures/Convulsions _____
[ ] Eye Problems-Crossed eye, Glaucoma, Cataracts _____
[ ] Family Violence/Domestic Abuse _____
[ ] Gastrointestinal Problems-Ulcers, IBS, Reflux, Inflammatory Bowel _____
[ ] Hearing Loss from birth-Congenital deafness ____ _____
[ ] Heart Disease-Under 50 yrs. _____
[ ] High Blood Pressure _____
[ ] High Cholesterol/Triglycerides _____
[ ] Immune Disorder _____
[ ] Infant Death-SIDS _____
[ ] Kidney Disease/problems _____
[ ] Learning Disabilities _____
[ ] Liver Disease-Jaundice _____
[ ] Mental Illness-Depression, Anxiety _____
[ ] Mental Retardation _____
[ ] Migraines _____
[ ] Obesity _____
[ ] Schizophrenia _____
[ ] Scoliosis _____
[ ] Sexually Transmitted Disease-AIDS, Syphilis _____
[ ] Stroke-Under 50 yrs. _____
[ ] Sudden Athletic Death-Arrhythmia _____
[ ] Tuberculosis (TB) _____
[ ] Thyroid/Hormone Problems _____
[ ] Rare Disease-Cystic Fibrosis, Multiple Sclerosis, Muscular Dystrophy, Neurofibromatosis _____
[ ] Explanations/Other Family Health Issues _____
_____
_____
_____
_____
_____
_____
_____

Please list any health concerns you have _____
_____
_____

Please list any medication your child is currently taking _____
_____
_____

Do you have any concerns about your child's development or behavior? [ ] Yes [ ] No

The following individuals are able to authorize medical treatment for my child(ren) in my absence:

Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____

P**arent or Guardian Signature** _____ **Today's Date** _____