Child's Name:_______________________________ **Date of Birth:** _________________

Newborn History

Please answer the following questions about your baby's medical and family history.
The physician may ask further details about "yes" answers.

PREGNANCY AND BIRTH:

Place of Birth:

Hospital Name____ City/State________________________

Did baby receive Hepatitis B in the Hospital? ____ YES ____ NO. Did Baby pass the hearing test? ____ YES ____ NO

Type of Delivery: Vaginal ______ C-section ________ Length ____________ Weight ____________

Was Baby full term _____ or early? ___________ If early, how many weeks? ______________________________

Is your child breastfed? _________ YES _________ NO Are you having problems breastfeeding? Please explain:

____

Complications:

	Yes	No
Where there any problems with pregnancy or delivery of this child?	____	____

If yes, please explain complications during pregnancy:____

____

Please explain complications after birth:____

____

Problems:

	Yes	No		Yes	No
Jaundice	_____	____	Breech	_____	____
Respiratory Distress	_____	____	Developmental Problems	_____	____
Feeding Problems	_____	____	If yes, please explain:________________________		
Rash	_____	____	____		

HOSPITALIZATIONS/OPERATIONS:

☐ NONE

Hospital Reason Year

____

____

____

MEDICATIONS AND DOSAGES **(Please include over the counter, supplements, homeopathic and prescribed medications):**

☐ NONE

____

____

____

ALLERGIES TO ANY MEDICATIONS? **(Please list)**

☐ NONE KNOWN

____

____

DOES YOUR CHILD SEE ANY SPECIALISTS? **(Nutritionist; Occupational, Physical, or other specialists)**

☐ NONE

Name of Specialist Reason

____

____

____

SOCIAL AND ENVIRONMENTAL HISTORY

	Yes	No
Does anyone living in the home smoke?	____	______
Does anyone living in the home drink alcohol?	____	______
Are there smoke detectors in the home?	____	______
Seat belts used in your car?	____	______
Is your child in or will be attending day care?	____	______
Are there guns in your home?	____	______
If yes, are the guns safely stored (i.e. Locked in a gun safe)?	____	______
Do you have the poison-control center phone number near your telephone?	____	______

See other side

Child's Name:_______________________________ **Date of Birth:** _________________

Please List Patient's Biological Parents:

Mother: ____ DOB:_________________________

Father: ____ DOB: _________________________

Does Patient live with Biological Parents? (Circle one) **YES** **NO**

*If **No** please indicate name of person patient is living with and relationship below:*

Name: ____ **Relationship to Patient:**_________________

FAMILY MEDICAL HISTORY **(Please fill out the following based only on biological family members of the patient)**

☐ CHECK HERE IF NONE OF THE CONDITIONS BELOW APPLY TO ANY BIOLOGICAL FAMILY MEMBERS

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other
ADD/ADHD						
Allergies						
Asthma						
Birth Defects						
Cancer						
Heart Problems						
Hip Problems						
Deafness						
Depression						
Developmental Delay						
Diabetes						
Eczema						
Genetic Disorder						
Blood Disorder						
High Cholesterol						
High Blood Pressure						
Learning Disability						
Intellectual Disability						
Migraines						
Obesity						
Curved Spine						
Seizure Disorder						
Sudden Infant Death						
Crossed Eyes						
Thyroid Disease						
Hepatitis						
Tuberculosis						
Other:						

Signature **Print Name** **Relationship to Patient** **Date**

See other side