Newborn Information and Medical History (Updated 08/2022)

Child's Full Name ________________________________**Date of Birth** ____________________

Address ____ **City** _________________________ **State** ___________
Zip Code ___________ **Phone Number** _______________________ **Alternate Phone Number** _______________________

Parent (1) Name ________________________________
Date of Birth __________________________________
Parent (1) SSN _________________________________
Parent (1) Occupation ___________________________
DoesParent (1) live with Child? [ ] Yes [ ] No

Parent (2) Name_____________________________________
Date of Birth _______________________________________
Parent (2) SSN_______________________________________
Parent (2) Occupation_________________________________
Does Parent (2) live with Child? [ ] Yes [ ] No

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

Emergency Contact (Name and Phone number) ____

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 min
Number of days 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 traditional 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 contractions?			
Have prescribed bed rest?			
Suffer physical or emotional abuse?			
Have any other complications?			

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-Autism,Speech Delay
____
[ ] Diabetes-Onset under 25yrs______________________
[ ] 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 -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 50yrs_____________________________
[ ] Sudden Athletic Death-Arrhythmia__________________
[ ] Tuberculosis(TB)_______________________________
[ ] Thyroid/Hormone Problems_______________________
[ ] Rare-Disease-Cystic Fibrosis,Multiple Sclerosis,Muscular Dystrophy,Neurofibromatosis_____________________
[ ] Explanations/Other Family Health Issues_____________
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____
____
____
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____

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 form 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 ____________________

Parent or Guardian Signature ______________________________ Today's Date ____________