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## NEWBORN/NEW PATIENT HISTORY FORM

Patient name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

### **Birth History**

Type of delivery: Vaginal or C-Section \_\_\_\_\_ Full Term or Premature \_\_\_\_\_ If Premature, # of weeks \_\_\_\_\_  
Hospital: \_\_\_\_\_ Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_  
Any complications in newborn nursery? Yes No If yes, explain \_\_\_\_\_  
Hep B given at hospital? Yes No \_\_\_\_\_ Breast fed or Formula \_\_\_\_\_ Formula brand \_\_\_\_\_  
Mom's Blood type: \_\_\_\_\_ Any family history of inherited diseases? Yes No  
If yes, please describe \_\_\_\_\_

### **Social History**

Any pets? Yes No If yes, please specify \_\_\_\_\_ Does anyone smoke in the home? Yes No  
Who lives with the child? \_\_\_\_\_

### **Family History: (serious or chronic illnesses of parents, siblings and grandparents)**

Diagnosis	Relation to Patient
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**\*For Newborns - Stop here \***

### **Past Medical History: (ex: significant or chronic illnesses and hospitalizations and date of onset)**

### **Past Surgical History:**

Date	Procedure	Hospital	Doctor
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- 1.
- 2.
- 3.
- 4.

### **Current Medications:**

Start Date	Medication	Dose
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- 1.
- 2.
- 3.
- 4.

### **Allergies: Food or Medication and Type of Reaction**

- 1.
- 2.
- 3.
- 4.