



NEWBORN HISTORY FORM

Patient name _____ **DOB** _____ **Date** _____

Birth History, Social History and Family History are very important aspects of pediatric care. Please complete as thoroughly as possible. If your family has a history of serious or chronic illnesses they need to be documented in your child's chart. If you have any questions about this please feel free to discuss with your provider.

Birth History - circle

Type of delivery: Vaginal or C-Section _____ Full Term or Premature _____ If Premature, # of weeks _____

Adopted _____ Egg Donor _____ Sperm donor _____

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 _____

Was there any routine treatment you DID NOT ACCEPT in the newborn nursery?

- Vitamin K injection
- Newborn Screen
- Eye ointment prophylaxis
- Hearing Screen
- Hepatitis B Vaccination
- Other (please list) _____

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:

Do any family members have any of the following conditions:

Condition	Mother	Father	Sibling
<u>Grandparent</u> Asthma			<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain all positives.			