(NEWBORN) New Patient Medical History

Patient Name: _____

Date of Birth: _____

Hospital of Birth: _____

Form Completed By _____ Relationship: _____

Maternal Pregnancy History

Condition	Yes	No	Details
Illness			
Medication			
Smoking			
Alcohol / Drug Abuse			
STD			
GBS Positive			Mom Received Abx: Yes No

Birth History

Type of Delivery: Vaginal C-Section			Gestation: Early (<37 weeks) Late (>41 weeks)		
Breech:	Yes	No	Passed hearing test:	Yes	No
Complications after birth:	Yes	No	Hepatitis B received:	Yes	No
Jaundice:	Yes	No	Received Vit K/ eye prophylaxis	Yes	No

Feeding

Breastfed   Formula-fed / Which Formula: _____

Family Medical History:

(Father-F, Mother-M, Brother-B, Sister-S, Maternal GPs-MM or MF, Paternal GPs-FF or FM, Uncle-U, Aunt-A)

Condition	YES	NO	Condition	YES	NO
Asthma			Learning/Attention Deficits		
Heart Disease			Cancer		
Hypertension (HTN)			Family Violence		
High Cholesterol (HLD)			Diabetes		
Blood disorders/sickle cell			Thyroid Disease		
Seizures			Sudden Death (BOLD)		
Migraines			Alcohol/Drug Abuse		
Hearing Loss			Other		
Vision Problems					

Please do not forget to complete the reverse side of this form

Details:

Family Profile

Total Family Members:	Adults:	Children:
Parents are:	Together Married Separated Divorced	
Child lives with:	Father Mother Two homes Other	
Pets:	Yes No (Type /number):	
Water Source:	Well City	
Exposure to Smoking:	Yes No	

Parents Name	Age	Occupation	Health Problems
			Yes No
			Yes No

Siblings of Patient	Age	Gender	Full/Half	Health Problems
				Yes No
				Yes No
				Yes No
				Yes No

Notes:

NICU stay   Yes   No (if No, skip section)

NICU Stay Details

			Details:
Resuscitation at delivery	Yes	No	
Hypothermia	Yes	No	
Sepsis screening labs	Yes	No	
Antibiotics	Yes	No	
Transcutaneous bilirubin (TcB)	Yes	No	
Jaundice	Yes	No	
Circumcision	Yes	No	
Delayed passage of meconium	Yes	No	
Heart Murmur	Yes	No	
Respiratory problems (TTN/RDS)	Yes	No	
Supplemental oxygen	Yes	No	
Assisted ventilation	Yes	No	
Apnea	Yes	No	
Head ultrasound	Yes	No	
Ophthalmologic conditions	Yes	No	

Please do not forget to complete the reverse side of this form