Newborn Pediatric Health Record (if less than 4 weeks)

DATE: _____

Dear Patients: Welcome to our office! While the following form may take a few minutes to complete, please fill in as much as possible, even the parts that do not seem important. The information that you provide will help us to take better care of your child today and in the future.

NAME:_____ SEX: M F RACE:(for insurance purposes) _____
DATE OF BIRTH:_____ AGE:_____
PARENT/GUARDIAN NAME:_____

GENERAL HEALTH AND DEVELOPMENT:
What is the chief reason that your child is being seen today? _____
_____
_____
_____

PREGNANCY AND BIRTH HISTORY (Please circle YES or NO to the following questions)

Did you have regular medical care while pregnant with this child?	YES	NO
Did you have any problems while pregnant with this child? (If yes, please explain)	NO	YES
Did you take any medications other than prenatal vitamins during this pregnancy? (If yes, please list)	NO	YES
Did you have an unusually long or difficult labor or delivery?	NO	YES
Was this child born in a hospital?	YES	NO
Was this child born head first?	YES	NO
Was this child born by cesarean section?	NO	YES
Your child's birth weight was lbs. oz.		
Was your child normal at birth?		
Was your child more than 2 weeks early or late?	NO	YES
Did this child go home from the hospital at the same time as you did?	YES	NO
Did your child have any unusual problems in the hospital?	NO	YES
Did your child need any special treatment while in the hospital such as an incubator, oxygen, blood transfusion,	NO	YES
IV, etc? (If yes, please explain)		
Did your child have a hearing screen and pass the screen prior to discharge from the hospital?	YES	NO
Did your child have the first HBV (hepatitis vaccine) prior to discharge from the hospital?	YES	NO

FAMILY HEALTH

	Age	Health if Living	Age at Death	Cause of Death
Father				
Mother				
Mother's mother				
Mother's father				
Father's mother				
Father's father				
Brothers/Sisters (include name)				
2				
3				
4				
5				

PATIENT NAME:_____ MR#:_____

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FAMILY HISTORY

Has any blood relative ever had:			**Has any blood relative ever had:**		
Heart trouble before age 50	NO	YES	Cancer	NO	YES
High blood pressure	NO	YES	Tuberculosis	NO	YES
Stroke before age 60	NO	YES	Diabetes	NO	YES
Lung disease before age 40	NO	YES	Anemia	NO	YES
Blindness before age 50	NO	YES	Sickle Cell Disease	NO	YES
CoJor blindness	NO	YES	Migraine	NO	YES
Nervous Breakdown	NO	YES	Asthma	NO	YES
Kidney trouble	NO	YES	Allergies/Hay fever	NO	YES
Easy bleeding	NO	YES	Obesity	NO	YES
Congenital malformations	NO	YES	Retardation	NO	YES
Convulsions or seizures	NO	YES	Deafness	NO	YES
Cystic Fibrosis	NO	YES	Thyroid trouble	NO	YES

Please list any other diseases which run on either side of your child's family _____

_____

_____

PATIENT NAME:_____ MR#:_____