Newborn Medical History Form

Date: _____

Welcome to The Pediatric Place! Please complete this form to provide us with information about your baby and family medical history. *Thank you!*

Child's Name: _____ **Date of Birth**: _____

Birth History ○ Boy ○ Girl ○ Adopted

Birth Weight: _____ Birth Hospital: _____ State: _____

○ Full-Term (≥37 wks) ○ Vaginal ○ C/Section due to: _____

○ Premature (<37 wks) # weeks_____ ○ Forceps ○ Vacuum

Pregnancy concerns: □ none concerns: _____

Newborn concerns: ○ none ○ jaundice if jaundice, did your baby need light phototherapy? ○ ○

□ other: _____

□ intensive care (NICU) stay due to: _____

_____

Family Hx:

Other Children (names/ages): _____ _____

_____ _____

Family Medical Conditions

(ex: asthma, heart disease, high blood pressure, diabetes, obesity, cancer-type, acid reflux, lupus, arthritis, hypo/hyper-thyroid, hearing/vision problem, seizures/epilepsy, kidney problem, liver problem, melanoma, eczema, psoriasis, bleeding/clotting disorder, ADHD, depression, schizophrenia, Alzheimer's, Parkinson's, etc.)

Baby's Mom_____

Baby's Dad_____

Baby's Sister/Brother_____

Baby's Grandparents_____

Cousins_____

Home Environment

Parents: ○ married ○ unmarried/live together ○ single-parent ○ divorced ○ remarried

Guns: ○ no ○ yes if yes, storage location: _____

Smokers: ○ no ○ yes if yes, where do you smoke: ○ inside ○ outside

Home: ○ house ○ apartment ○ condominium

Pets: ○ no ○ yes if yes, what kind? _____

Occupation: Mom _____ Dad _____

How did you find out about our pediatric practice?

_____