Initial History Questionnaire- Newborn

Patient Name:	Birth Date:
Age:	Gender: M F
Form Completed By:	

HOUSEHOLD - *Please list all those living in the child's home*

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their name and age and where they live._____

_____

If mother & father are not living together, or if child does not live with parents, what is the child's custody status?_____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in home? _____

_____

Mother's Occupation_____ Mother's Employer_____

Father's Occupation _____ Father's Employer_____

Does anyone in the home use tobacco? ☐ Yes ☐ No Are there any pets in the home? ☐ Yes ☐ No

BIRTH HISTORY

Birth Weight_____

Was the baby born at term? ☐ Yes ☐ No ☐Early ☐ Late

If early, how many week's gestation?_____

Did mother have any illness/problems with pregnancy?

☐ Yes ☐ No Explain_____

_____

During pregnancy, did mother

Smoke? ☐Yes ☐No Drink alcohol? ☐ Yes ☐No

Use drugs or medications ☐ Yes ☐ No

What _____ When _____

Was delivery ☐Vaginal ☐ Cesarean?

If Cesarean, why? _____

Did your baby have any issues right after birth?

☐ Yes ☐ No Explain _____

_____

Was initial feeding ☐Breast ☐Bottle

Did the baby go home with mother from hospital?

☐ Yes ☐ No Explain: _____

GENERAL

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain_____
Does your child have a serious illness or medical condition?	☐ Yes	☐ No	Explain_____
your child had serious injuries or accidents?	☐ Yes	☐ No	Explain_____
Has your child had surgery of any kind?	☐ Yes	☐ No	Explain_____
Has your child ever been hospitalized?	☐ Yes	☐ No	Explain_____
Is your child allergic to any medicines or drugs?	☐ Yes	☐ No	Explain_____

Please proceed to back page

FAMILY HISTORY

Has any family member had the following:

Deafness?	☐ Yes	☐ No	Who_____	Comments _____
Nasal allergies?	☐ Yes	☐ No	Who_____	Comments _____
Asthma?	☐ Yes	☐ No	Who_____	Comments _____
Tuberculosis?	☐ Yes	☐ No	Who_____	Comments _____
Heart disease (before 50 years old)?	☐ Yes	☐ No	Who_____	Comments _____
High blood pressure (before 50 years old)?	☐ Yes	☐ No	Who_____	Comments _____
High cholesterol?	☐ Yes	☐ No	Who_____	Comments _____
Anemia?	☐ Yes	☐ No	Who_____	Comments _____
Bleeding disorder?	☐ Yes	☐ No	Who_____	Comments _____
Liver disease?	☐ Yes	☐ No	Who_____	Comments _____
Kidney disease?	☐ Yes	☐ No	Who_____	Comments _____
Diabetes (before 50 years old)?	☐ Yes	☐ No	Who_____	Comments _____
Bed-wetting (after 10 years old)?	☐ Yes	☐ No	Who_____	Comments _____
Epilepsy or convulsions?	☐ Yes	☐ No	Who_____	Comments _____
Alcohol abuse?	☐ Yes	☐ No	Who_____	Comments _____
Drug Abuse?	☐ Yes	☐ No	Who_____	Comments _____
Mental illness?	☐ Yes	☐ No	Who_____	Comments _____
Mental retardation?	☐ Yes	☐ No	Who_____	Comments _____
Immune problems, HIV or AIDS?	☐ Yes	☐ No	Who_____	Comments _____

Additional family history?

_____

_____

_____