



Please fill out and return.

**Newborn Health History**  
All information in this questionnaire is confidential  
and will be of your child's medical record.  
For new patients less than 3 months old.

Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male / Female  
Last, First, MI

**Other Healthcare Practitioners:**

name	type of practice	phone no.
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Immunizations / Plan** (include dates if known)

DTP \_\_\_\_\_ Hep B \_\_\_\_\_  
 Polio \_\_\_\_\_ MMR \_\_\_\_\_  
 Hib \_\_\_\_\_ Chickenpox (Varicella) \_\_\_\_\_  
 other \_\_\_\_\_

**Prenatal History:**

- YES NO
- Gestational Diabetes \_\_\_\_\_
  - Group B Strep \_\_\_\_\_
  - Hypertension \_\_\_\_\_
  - Smoking during pregnancy \_\_\_\_\_
  - Alcohol or recreational drug use during pregnancy \_\_\_\_\_
  - Other significant health details \_\_\_\_\_

**Birth History:** Vaginal / Cesarean / Forceps / Vacuum / Trauma?

On time,  Before 37 weeks of pregnancy,  After 42 weeks of pregnancy?

**Illness:** Any newborn problems? jaundice / hospitalization / other (describe)  
\_\_\_\_\_

Diet & Environment

Feeding Plans? breastmilk only / formula / mixed \_\_\_\_\_

How many children in your home? \_\_\_\_\_

This child's birth order (i.e., 3rd of 4 kids...)? \_\_\_\_\_

What adults live with your child? \_\_\_\_\_

Child care plan? \_\_\_\_\_ # hours/week \_\_\_\_\_

YES NO

Does your home have adequate heat, a telephone and enough food? \_\_\_\_\_

Was your home built before 1950? \_\_\_\_\_

Does your home have mold? \_\_\_\_\_

Is your home safe? \_\_\_\_\_

Family History - Is your child adopted? YES / NO

Have any family members had the following? If so, note the relationship to the child.

	YES	NO		YES	NO
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Allergies / Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes before age 50	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting after age 10	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease before age 50	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy of convulsions	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure before age 50	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug abuse	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>

Any other information you would like us to know about your child? \_\_\_\_\_

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