HOWARD COUNTY PEDIATRICS, LLC.

Newborn Information and Medical History

Child's Full Name _____ Date of Birth _____

Parent Name _____
Relation_____
Occupation _____
Does this parent live with child? ☐ Yes ☐ No

Parent Name _____
Relation_____
Occupation _____
Does this parent live with child? ☐ Yes ☐ No

Legal Guardian Name _____
Is the child adopted? ☐ Yes ☐ No
Is the child in foster care? ☐ Yes ☐ No

Name of siblings/Birthdates
_____ ___/___/___
_____ ___/___/___
_____ ___/___/___
_____ ___/___/___

Mother's age at birth _____ Father's age at birth _____
Birth Hospital _____
Type of delivery ☐ Vaginal ☐ C-section
Birth weight _____ lbs _____ oz Weight on day of discharge _____ lbs _____ oz
APGAR scores if known _____ 1 min _____ 5 mins
Number of days baby stayed in hospital after birth _____
Do you feel sad or depressed since the birth of the baby? ☐ Yes ☐ No ☐ Not sure ☐ I'm not the birth mother

Birth History

	Yes	Please give details
Was baby born early?		How many weeks?
Did baby need any help breathing after delivery?		
Did/does the have jaundice (yellow skin)?		
Did baby spend any time in Newborn Intensive Care (NICU)?		
Were forceps or vacuum used to deliver baby?		
Was a heart murmur present after delivery?		
Does baby have any unusual birthmarks or skin tags?		
Does baby have any conditions diagnosed *before* birth?		
Was baby born outside of a traditional hospital? (home, birthing center, car, etc.)		
Did baby receive the first Hepatitis B vaccine?		
Did baby pass the hearing screen in the hospital?		

Pregnancy History

While pregnant with *this* child did the mother . . .	Yes	When	Explain (include dates if known)
Drink alcohol/beer?			
Smoke cigarettes?			
Use illicit drugs? (marijuana, cocaine, etc)			
Take medications other than vitamins?			
Have diabetes?			
Test positive for Group B strep?			
Have any other illnesses or diseases?			
Have early contractions?			
Have prescribed bed rest?			
Suffer physical or emotional abuse?			
Have any other complications?			

Family History

Check if a family member *other than the child* has ever had any of the following – WHO?

☐ Asthma
☐ Diabetes
☐ Heart disease before age 55
☐ High cholesterol
☐ High blood pressure
☐ Sudden death from unknown cause
☐ Complications from anesthesia
☐ Schizophrenia
☐ Depression
☐ Cancer
☐ HIV/AIDS
☐ Thyroid problems
☐ Kidney problems
☐ Tuberculosis
☐ Sickle cell disease

Parent or Guardian Signature _____ Today's Date _____

Reviewed By:_____ Date:_____