NEWBORN MEDICAL HISTORY

(0 - 2 months)

In order to provide better care to your baby, please help us by completing this medical history. Please let us know if you need any help completing the form.						
Patient Name:			**DOB:**			
Source of information: [ ] Mother [ ] Father [ ] Family member [ ] Another person						
MOTHER'S HISTORY						
Mother's Age today?						
List maternal illness before or during pregnancy (physical or mental)?						
Has mother felt down, depressed or hopeless in the last 2 weeks?					□ Yes	□ No
PREGNANCY						
In what month did mother seek prenatal care?			□ 1-3 months	□ 4-6 months	□ 7-9 months	
Complications during pregnancy?					□ Yes	□ No
Did mother use any Medications during pregnancy other than prenatal vitamins?					□ Yes	□ No
Did mother use illegal drugs during pregnancy?					□ Yes	□ No
Did mother use alcohol during pregnancy?					□ Yes	□ No
Did mother smoke tobacco during pregnancy?					□ Yes	□ No
LABOR AND DELIVERY						
Length of pregnancy in weeks at the time of delivery?						
How was your baby born?			□ vaginally or □ C-section			
Were there complications after delivery?					□ Yes	□ No
Did mother receive anesthesia or other drugs during delivery?					□ Yes	□ No
Were forceps used?					□ Yes	□ No
BABY'S HISTORY						
Was the Hepatitis B vaccine administered?					□ Yes	□ No
Birth weight?		ounces	Yellow coloring of the skin?		□ Yes	□ No
Breastfeeding?	□ Yes	□ No	Formula feeding?		□ Yes	□ No
What type of formula do you use?						
Number of ounces per feeding?	□ 1 oz.	□ 2 oz.	□ 3 oz.	□ 4 oz.	□ 5 oz.	
Frequency of feedings?	□ 1/2 hour	□ 1 hour	□ 2 hours	□ 3 hours	□ 4 hours	
Number of wet diapers per day?		□ 1-3 diapers	□ 4-7	□ 8-11	□ 12-15	
Does your baby have hard stools?					□ Yes	□ No
In what position do you put your baby to sleep? (please circle one)				Back	Belly	Side
Do you use a car seat?					□ Yes	□ No
Do you receive WIC services?					□ Yes	□ No
Is your baby exposed to second-hand smoke?					□ Yes	□ No
Is there a crib or adequate crib substitute for the baby?					□ Yes	□ No
FATHER'S HISTORY						
List below any significant illness (physical or mental).						
FAMILY HISTORY						
Please list below any significant illness (physical or mental) in other members of the immediate family.						

Name of the person completing the form: _____Date: _____ 5/28/2015