

# Newborn History Questionnaire

Date \_\_\_\_\_

Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone (Home) \_\_\_\_\_

Work (Father) \_\_\_\_\_

Work (Mother) \_\_\_\_\_

|                            | Name of: | Birth Date | Occupation | Healthy? |
|----------------------------|----------|------------|------------|----------|
| Father                     | _____    | _____      | _____      | _____    |
| Mother                     | _____    | _____      | _____      | _____    |
| Brothers &<br>Sisters      | _____    | _____      | _____      | _____    |
|                            | _____    | _____      | _____      | _____    |
| Others living in household | _____    | _____      | _____      | _____    |
|                            | _____    | _____      | _____      | _____    |

Are natural parents living together?      Yes \_\_\_\_\_      No \_\_\_\_\_

If no, please explain: \_\_\_\_\_

Birth Weight \_\_\_\_\_      Length \_\_\_\_\_

Please circle correct response:

- |  |        |           |
|--|--------|-----------|
| Was pregnancy normal or difficult?     | Normal | Difficult |
| Was delivery normal or difficult?      | Normal | Difficult |
| Was the baby full term?                | Yes    | No        |
| Did baby have any problems in nursery? | No     | Yes       |

**Family History** — Check any of the following diseases which relatives (including aunts, uncles, cousins, grandparents) have:

|   |       |   |       |
|---|-------|---|-------|
| Seizure Disorder                                | _____ | Anemia or Blood Problems                                | _____ |
| Tuberculosis                                    | _____ | Alcoholism  | _____ |
| Asthma  | _____ | Kidney Disease  | _____ |
| High Blood Pressure                             | _____ | Cystic Fibrosis   | _____ |
| Heart Attack, Stroke<br>(under 55 years of age) | _____ | Cancer  | _____ |
| Diabetes  | _____ | Mental Retardation                                      | _____ |
| Obesity   | _____ | Birth Defects   | _____ |
| High Cholesterol or<br>Triglycerides            | _____ | Psychiatric Problems                                    | _____ |
|   |       | Death before 50 years of<br>age, other than<br>accident | _____ |

Please give details of diseases checked here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list cause of death of close relatives to this child:

| Name  | Relationship to Child | Cause of Death |
|-------|-----------------------|----------------|
| _____ | _____                 | _____          |
| _____ | _____                 | _____          |
| _____ | _____                 | _____          |
| _____ | _____                 | _____          |

**Present History**

Are there any problems that you would like to discuss with the Pediatrician?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Reviewed by: (MD, NP, PA)  
 Signature

Date