Newborn-6 Months New Patient History 2019

Today's Date _____ _____ _____
Child's Name Date of Birth

Person completing form: _____ Relationship to child: _____

Do you have any concerns about your baby? ❑ No ❑ Yes Explain _____

How are you feeding your baby?: ❑ breast milk ❑ formula ❑ both Explain_____

If nursing, ___ times per day, for _____ minutes each time If using a bottle, ____ times per day, ____ ounces each feeding

Are you (mom or dad) feeling sad or depressed? ❑ No ❑ Yes Explain _____

Do you have everything you need to take care of your baby? ❑ No ❑ Yes Explain _____

Mom's Pregnancy History	No	Yes	Explain
Take any medications during pregnancy?			
Use alcohol during pregnancy?			
Smoke or use e-cigarettes during pregnancy?			
Use marijuana during pregnancy?			
Use drugs (meth, cocaine, heroin, etc.) during pregnancy?			
Was baby breech at delivery or during the third trimester?			
Have diabetes before or during pregnancy?			
Abnormal ultrasound?			
Any infections during pregnancy?			
High blood pressure during pregnancy?			
Mom have any health problems during this pregnancy?			
Assisted conception/IVF			
High risk pregnancy?			
Little or late prenatal care?			
Baby have any health problems during pregnancy?			
Any of the following positive during pregnancy?	❑ Hepatitis B ❑ HIV ❑ Syphilis ❑ Gonorrhea ❑ Chlamydia ❑ Group B strep (UTI or 36 week culture) ❑ Herpes If yes, taking medication? ❑ Yes ❑ No		

Where was baby delivered? _____ How many weeks of pregnancy at birth? _____

Mom's OB or midwife: _____

Delivery History (SKIP IF DR. PULLIAM SAW YOUR BABY AT PIEDMONT HENRY)			
	No	Yes	Details
Was labor induced?			
Type of birth ❑ vaginal ❑ C-section reason:			Epidural? ❑ No ❑ Yes
Did baby need help to start breathing?			
Water broken more than 18 hours before delivery?			
Mom have antibiotics during labor?			
Apgar scores			
Any abnormalities at birth?			
Admitted to transition nursery at first?			
Admitted to NICU?			
Skin to skin with baby after delivery?			
Problems during delivery?			
Mom health problems after delivery?			
Breastfeed after delivery?			
See a lactation consultant in hospital?			
Any problems breastfeeding while in the hospital?			

Additional details: _____

_____

Newborn hospital history ❑ SKIP IF DR PULLIAM SAW YOUR BABY IN THE HOSPITAL				
Did child have any: (DK-don't know)	No	Yes	DK	Explain/details
Low blood sugar				
Jaundice				
Given antibiotics				
Tested for infection				
Blood antibody (Coombs) test +				
Heart murmur				
See any specialists				
Any other problems?				
Did baby receive				
Vitamin K				
Antibiotic eye ointment				
Hepatitis B vaccine				
Hearing screen result				❑ Pass both ears ❑ Refer/failed/needs repeating
Jaundice risk result				❑ Low risk ❑ Low intermediate risk ❑ High intermediate risk ❑ High risk

For Infants more than 2 weeks old				
	No	Yes	DK	Explain/details
Any health problems since going home?				
Jaundice?				
Poor weight gain				
Breastfeeding problems				
Newborn screening result?				
When did baby get back to birthweight?				
Seen any specialists?				
Hospitalized?				
Surgeries?				

SOCIAL HISTORY

Please list everyone who lives at home

(use page 4 if additional space is needed)

Name	Relationship to child	Age

OTHER HISTORY

Foster care? ❑ Yes ❑ No

Pets in home? ❑ No ❑ Yes

Smokers in home? ❑ No ❑ Yes

In daycare ❑ No ❑ Yes

Where does child sleep? _____

Do you have any concern about:	No	Yes	Explain
Abuse, family violence or exposure to violence			
Unsafe neighborhood or school			
Tobacco, alcohol, or drug use			
Having enough to eat or healthy food to eat			
Having a place to live			
Exposure to toxins (mold, lead, etc.)			
Death in the family or loss of parent due to divorce			
A safe place for your child to play and be active			

Additional details: _____

PLEASE SEE NEXT PAGE

GENETIC FAMILY HISTORY

Child's Name: _____

_____ Biological Mother

_____ Biological Father

Use this form ONLY for children who have the SAME genetic (biological) father and mother.
MARK BOX IF any of your child's BIOLOGICAL/GENETIC parents, brothers or sisters, grandparents, aunts or uncles, ever had any of the following conditions (blood relatives only). B=brother; S=sister; GM=grandmother; GF=grandfather; A=Aunt; U=Uncle

				MOTHER'S SIDE			FATHER'S SIDE		
Condition	Mom	Dad	Full sibling B or S	Half- sibling B or S	Grandparent GM or GF	Aunt (A) or Uncle (U)	Half-sibling B or S	Grandparent GM or GF	Aunt (A) or Uncle (U)
Example	✓		***S***	***S***	***GF***	***U***			***A***
Genetic or metabolic disease or syndrome									
Is anyone a carrier for any genetic disease									
Down syndrome or other chromosome problem									
Heart or any other defect present at birth									
Sudden, unexpected, or unexplained infant death									
Partial or total deafness hearing loss as a child									
Vision problem or blindness as a child									
Learning disabilities, mental retardation, or autism									
Developmental disability or disorder									
ADD/ADHD									
Seizures, convulsions or epilepsy									
Muscle disease or muscular dystrophy									
Eczema, many birthmarks, or other skin condition									
Bleeding disorder or hemophilia									
Severe anemia, sickle cell trait or disease									
Asthma, serious lung disease, or cystic fibrosis									
Severe allergies or eczema									
Heart disease, heart attack, or stroke before age 55									
Marfan syndrome or heart arrythmia									
Implanted pacemaker or defibrillator									
Sudden or unexplained death before age 50									
Unexplained fainting, drowning, car accident									
Childhood cancer or leukemia									
Other cancer or tumors before age 50									
Diabetes in childhood or Type 2 diabetes									
Obesity									
High blood pressure/hypertension									
High cholesterol or triglycerides									
Kidney disease									
Thyroid or other hormone/endocrine problems									
Liver or celiac disease or bowel disease									
Depression or anxiety									
Other mental health condition or mood disorder									
Alcohol or substance abuse problems									