New Hope Children's Clinic

NEWBORN HISTORY FORM

(For Children LESS than 5 years old)

Child's Name: _____ Age:____

Was this child adopted? No or YES Race/Ethnicity: _____

Who has legal custody of this child?_____

BIRTH HISTORY:

Date of Birth: _____Birth Place: _____

Was the baby full term: _____ If early, how early?_____

Birth weight: _____ Did the baby require a NICU Stay? No or YES (how long____)

Were there any problems with the delivery?_____

C-Section? NO or YES

Did the baby pass the hearing screen? No or YES

Any problems while in the nursery (jaundice, feeding problems, infections)?

_____

MOTHER'S PREGNANCY HISTORY:

Were there any problems during the pregnancy (diabetes, high blood pressure, infections)? No or YES

*Please list:*_____

Did the birth mother receive any vaccines or take any medicines during pregnancy? No or YES

Please list: _____

Was the birth mother treated for any infections during pregnancy? No or YES

Please list: _____

During the pregnancy, was the birth mother diagnosed or treated for any of the following?

Gonorrhea: No or Yes HIV: No or Yes HEP C: No or Yes

Chlamydia: No or Yes Hep B: No or Yes

Do you know the birth mother's Group B Strep status (test done by OB at end of pregnancy)? No or YES

Please select one: GBS+ or GBS- or GBS Unknown

Did the birth mother use alcohol, tobacco, or other drugs during this pregnancy? No or YES

Please list: _____

How many times has birth mother been pregnant? _____Any premature births? No or YES How Many: _____

Any stillbirths or spontaneous abortions? _____How many living children does she have? _____

FEEDING HISTORY:

Breast feeding or Bottle feeding? _____

If bottle feeding, what type of formula: _____

MEDICATIONS:

Please list any vitamins or medications your baby is taking now:_____

ALLERGIES:

Please list any allergies to foods or medications:_____

This Form Completed by:

Name: _____Relation to Child: _____

Date: ____

Reviewed by Medical Provider:______________________