

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: _____

BIRTH HISTORY:

Date of Birth: _____ Birth Place: _____
Was the baby full term: _____ If early, how early? _____
Birth weight: _____ Did your baby require a NICU Stay? No or YES (how long _____)
Were there any problems with the delivery? _____
C-Section? NO or YES
Did your 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 your pregnancy (diabetes, high blood pressure, infections)? No or YES

Please list: _____

Did you receive any vaccines or take any medicines during pregnancy? No or YES

Please list: _____

Were you treated for any infections during pregnancy? No or YES

Please list: _____

During the pregnancy, were you 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 your 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 you use alcohol, tobacco, or other drugs during this pregnancy? No or YES

Please list: _____

How many times have you been pregnant? _____ Any premature births? No or YES How Many: _____

Any stillbirths or spontaneous abortions? _____ How many living children do you 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: _____