

NEW PATIENT MEDICAL HISTORY – Newborn to 6 months

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THIS FORM MUST BE COMPLETED AND RETURNED BEFORE 1ST VISIT
WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES

The following is **very important** to your child's health. Please complete it **accurately** and **completely**.

Child's name: _____ **Birth date:** ____/____/____

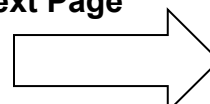
Where was your child born? _____ Is child adopted or fostered? Y____ N____

Has your child **ever** previously been seen by any of the doctors **in this practice**? Y____ N____

In this **FAMILY** medical history – if you answer **YES** – please check off which **BIOLOGICAL RELATIVE** has the condition
 Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather
 List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	NO	YES	If YES - Please check which biological relative						
			Mom	Dad	Sib	Maternal	Maternal	Paternal	Paternal
						Gr Mth	Gr Fth	Gr Mth	Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Mental retardation or developmental disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

SOCIAL HISTORY		No	Yes	
Lives with both mother and father in same house				
Non-intact home - give custody status				Lives with:
Does non-custodial parent have visitation rights?				
Are there Siblings?				Live in same house?
Are there pets in the home?				
Are there guns in the home?				
Are guns locked and kept separate from ammunition?				
Other issues:				



Birth Weight: _____ lb _____ oz		Birth Length: _____ inches		Head Cir _____	Chest _____
NEWBORN HISTORY – while in hospital		No	Yes	If YES - explain	
Resuscitation at delivery (needed help to start breathing/crying)					
Premature infant					
Did NOT get vitamin K and / or eye prophylaxis					
Feeding: Breast milk or formula? Or both?				Formula Type:	
Hypoglycemia (low blood sugar)					
Hypothermia (low temperature)					
Sepsis screening labwork (to check for infection)					
Elevated Bilirubin (jaundice)					
Circumcision					
Delayed passage of first bowel movement					
Heart Murmur					
Breathing problems					
Needed oxygen or help breathing					
Needed antibiotics while in nursery					
Apnea (stopping breathing)					
Needed head ultrasound					
Needed ophthalmologic (eye) exam					
Was HEP B given in Hospital?					
Was Newborn Hearing done in Hospital				Pass or Did not Pass	
Other issues:					
MOTHERS PRENATAL HISTORY		No	Yes	If Yes - explain	
Was this an assisted conception (had to have help getting pregnant)?					
Was this a High Risk Pregnancy?					
Did you have Amniocentesis / CVS?					
Did you have little or late prenatal care?					
Did you use alcohol or tobacco while pregnant?					
Did you use any non-prescription drugs while pregnant?					
Was there any problem with your maternal health?					
Was there any problem with the baby before born?					
Water broke more than 24 hours before delivery?					
Did you have antibiotics or other medications during labor?					
Was your labor induced (started by medications)?					
Was this delivery vaginal or by C-section?					
Was there meconium (green bowel movement) present when your water broke?					
Is Mother up to date on the TDAP Vaccine					
Other Issues:					

Is there anything else regarding your child's health that you think we should know that has not already been asked?

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: _____ Relationship to patient: _____

Print Name: _____ Today's Date: _____ / _____ / _____