Newborn- 3 months History Questionnaire

(If filling out during your prenatal consult, please fill out as much as possible before delivery a
form during your first visit)
Prenatal Consult: Due Date: _____ Delivering at: _____

Family Last Name: _____
Mom's Name: _____ Mom's Maiden Name: _____
Dad's Name: _____
CHILD'S NAME: _____ | DOB _____
FORM COMPLETED BY: _____

Household

What is the child's living situation?
Lives with:
___ Biological Parents ____ Adoptive Parents
___ Foster Family ____ Joint Custody
____ Single Custody (if so, who do they live with: _____)
___ Other: _____

Please list all those living in the child's home:

Name:	Relationship to Child:	Birth Date:

Birth History ___ I do not know the birth history

Born at _____ weeks and was delivered by _____ (vaginal or cesarean).
If cesarean, why? _____
Was the baby breech? Yes No
Was the baby conceived by IVF or other forms of assisted fertility? Yes No
If yes, did you use a donor egg or donor sperm? _____
Were there any prenatal or neonatal complications? Yes No
Explain: _____
Any prenatal ultrasound abnormalities? Yes No
Explain: _____
Was a NICU stay required? Yes No
Explain: _____

Infant currently feeding by Formula or Breast Milk

During pregnancy, did mother:
Use tobacco Yes No
Drink alcohol Yes No
Use drugs Yes No
Use Prenatal Vitamins Yes No
Take medication Yes No
Explain:_____

Any other information you feel the pediatrician should know?
_____

Biological Family History ___ I do not know(DK) the birth history

1st or 2nd generation family members (grandparents, parents, aunts, uncles, cousins) with the following?

Does anyone in your family have:	Y	N	DK	If yes, which family member?
Food Allergies				
Nasal Allergies				
Asthma				
Bedwetting (after 6 years old)				
Dental Decay				
Childhood hearing loss				
Eye Disorders/ Congenital Abnormalities/ Retinoblastoma				
Epilepsy/ Seizures				
Migraines or other Neurological Disorder				
Developmental Disabilities				
Autism/ Cognitive Delay				
ADHD				
Immune Problems, HIV, Tuberculosis				
Thyroid Problems or other Endocrine Disease				
Autoimmune Disease				
Anemia				
Genetic or Heritable Disease				
Bleeding or Blood Disorder				
Stomach/ Intestinal Problems				
Liver Disease				
Kidney Disease/ Urologic Malformations				
Heart Abnormalities (congenital heart disease, valve abnormalities, arrhythmias, hypertrophic cardiomyopathy, etc.)				
Hypertension/ High Blood Pressure				
High Cholesterol or takes cholesterol medication				
Heart Attack (before age 60)				
Diabetes				
Obesity				
Cancer (before age 55)				
Depression				
Anxiety				
Eating Disorder				
Other mental illness				
Does either parent smoke cigarettes?				
Is the child exposed to cigarettes on a regular basis?				
Substance/ Drug Abuse				
Are there guns in the house?				
Do your children visit any house where guns are kept?				

Other Medical History:

_____

_____

_____