**Newborn Questionnaire**

Patient Name:_______________________________ Birthdate:________________

Referred By:________________________________ OB/GYN:________________

Mother's Name:______________________________ Birthdate:________________

Father's Name:_______________________________ Birthdate:________________

**Pregnancy History**

Gestation:________________ Problems:__________________________________

Medications:__________________________ Drugs___ Alcohol ___ Smoking___

Previous pregnancies (delivery type, sex, weight, complications)____________________
______________________________________________________________________
______________________________________________________________________

**Birth History**

Birth Weight______________ Length______ APGARS___________

Vaginal ____ C-Section ____ Hepatitis vaccine given at birth? Yes or No

Blood Type: Mom ____ Baby ____ Hospital delivered at?______________________

Complications:__________________________________________________________

**Family History**

| | | | |
|---|---|---|---|
| Childhood Deaths | ____ | Seizures | ____ |
| Asthma | ____ | Sickle Cell | ____ |
| Allergies | ____ | Diabetes | ____ |
| Heart Problems | ____ | Psychiatric Disorders | ____ |
| High Cholesterol | ____ | Deafness | ____ |
| Cystic Fibrosis | ____ | Learning Disability | ____ |
| Cancer | ____ | Thyroid Problems | ____ |

Other__________________________________________________________

**Social History**

Childcare Arrangements____________________________________________

Family/Friends Support_____________________________________________

**Postnatal History**

Breastfeed ____ Bottlefeed ____ Which formula?_________

Circumcised? (if boy) Yes ____ No ____

Any problems or concerns?__________________________________________

**Completed By:**______________________________ **Date:**___________________