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# Patient History Questionnaire-Newborn

**Child's First Name:** _____ **MI:** _____ **Last Name:** _____

**Gender: M ( ) F ( ) DOB:** _____ **Nick Name If Any:** _____

**Mother's Name:** _____ **Age:** _____**Occupation:** _____

**Father's Name:** _____ **Age** _____ **Occupation:** _____

**Has your child had any immunization? (Baby Shots)**_____ Date: _____

Parents are: Married _____ Single _____ Separated_____ Divorced _____ Remarried _____

## Household

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

| Name | Relationship to child | Birth date | Health problems |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

_____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

_____

## Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

_____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

_____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

_____

_____

_____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

_____

_____

_____

## Biological Family History DK = don't know

Have any family members had the following?

| | | | | | |
|---|---|---|---|---|---|
| Childhood hearing loss | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Nasal allergies | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Asthma | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Tuberculosis | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Heart disease (before 55 years old) | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| High cholesterol/takes cholesterol medication | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Anemia | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Bleeding disorder | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Dental decay | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Cancer (before 55 years old) | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |

## Past History DK = don't know

Does your child have, or has your child ever had,

| | | | | |
|---|---|---|---|---|
| Chickenpox | ☐ Yes | ☐ No | ☐ DK | When _____ |
| Frequent ear infections | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Problems with ears or hearing | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Nasal allergies | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Problems with eyes or vision | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Any heart problem or heart murmur | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Anemia or bleeding problem | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Blood transfusion | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| HIV | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Organ transplant | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Malignancy/bone marrow transplant | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Chemotherapy | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Frequent abdominal pain | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Constipation requiring doctor visits | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Recurrent urinary tract infections and problems | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Congenital cataracts/retinoblastoma | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Metabolic/Genetic disorders | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Cancer | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Kidney disease or urologic malformations | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Bed-wetting (after 5 years old) | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Sleep problems; snoring | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Chronic or recurrent skin problems (eg, acne, eczema) | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Frequent headaches | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Convulsions or other neurologic problems | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Obesity | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Diabetes | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Thyroid or other endocrine problems | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| High blood pressure | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| History of serious injuries/fractures/concussions | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Use of alcohol or drugs | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Tobacco use | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| ADHD/anxiety/mood problems/depression | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Developmental delay | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Dental decay | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| History of family violence | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Sexually transmitted infections | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Pregnancy | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| (For girls) Problems with her periods | ☐ Yes | ☐ No | ☐ DK | Explain _____ |

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

_____