Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

NEWBORN HISTORY FORM

GENERAL PATIENT INFORMATION

Date _____

Newborn/Patient's Name _____

Date of Birth _____ Place of Birth _____

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Who does the child/patient live with? ❑ **Both Parents** ❑ **Mother** ❑ **Father** ❑ **Other:** _____

Number of people in household _____

Why is the newborn here today? _____

_____

MEDICAL HISTORY

1. Allergies & Reactions

Allergy to Latex? ❑ **Yes** ❑ **No**

If yes, reaction: _____

Please provide a detailed list of any other allergies (i.e., medications, vaccinations, environmental, food, etc.) the newborn has and reactions experienced from each:

Allergy	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*If more space needed, please continue on back of this page.

2. Immunizations – **please provide copy of immunization record**

Has the newborn received all childhood immunizations? ❑ **Yes** ❑ **No**

3. Has the newborn had any surgeries? ❑ **Yes** ❑ **No**

If yes, please list any surgeries and respective years the surgeries were performed.

_____

_____

_____

4. Please list any prescription and over-the-counter medications, herbs, and vitamins the child/patient is currently taking:

Name	*Dose*	*Frequency*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*If more space needed, please continue on back of this page.

5. Has the newborn ever had any of the following?

Chicken Pox	❑ **Yes** ❑ **No**	Gallbladder problems	❑ **Yes** ❑ **No**
Measles	❑ **Yes** ❑ **No**	Ulcers	❑ **Yes** ❑ **No**
Mumps	❑ **Yes** ❑ **No**	Urinary Tract Infections	❑ **Yes** ❑ **No**
Rubella	❑ **Yes** ❑ **No**	Kidney Infections	❑ **Yes** ❑ **No**
Meningitis	❑ **Yes** ❑ **No**	Kidney Stones	❑ **Yes** ❑ **No**
Tuberculosis	❑ **Yes** ❑ **No**	Asthma	❑ **Yes** ❑ **No**
Anemia	❑ **Yes** ❑ **No**	Thyroid Disorder	❑ **Yes** ❑ **No**
Diabetes	❑ **Yes** ❑ **No**	Stroke	❑ **Yes** ❑ **No**
Rheumatic Fever	❑ **Yes** ❑ **No**	Kawasaki Disease	❑ **Yes** ❑ **No**

BIRTH HISTORY

Is the child yours by: ❑ **Birth** ❑ **Adoption** ❑ **Stepchild** ❑ **Other:** _____

Medical problems during pregnancy? ❑ **None** ❑ **Other:** _____

Born by: ❑ **Vaginal birth** ❑ **Cesarean**

If premature, why? _____

Birth weight: _____ Birth length: _____

Discharge weight: _____

NUTRITION & FEEDING

Newborn fed by: ❑ **Breast** ❑ **Bottle** ❑ **Both**

How many ounces per day? _____

SLEEP PATTERNS

Hours per night: _____

Does the newborn nap? ❑ **Yes** ❑ **No**

If yes, how many hours per day? _____

Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

FAMILY HISTORY

Does the newborn's family have a history of thyroid disorders? ❑ **Yes** ❑ **No**

If yes, please specify. _____

_____

_____

Please fill the following table out to the best of your knowledge:

	If Living Age	Health Status	If Deceased Age	Cause
Father				
Mother				
Siblings				
1				
2				
3				
4				
Children				
1				
2				
3				
4				

Has any blood relative ever had:	YES	Relationship (specify mother or father's side)	Age at Onset
Heart Disease			
Cancer – what kind?			
Glaucoma			
High Blood Pressure			
Asthma			
Osteoporosis			
Epilepsy			
Alzheimer's			
Stroke			
Suicide/Attempt			
Tuberculosis			
Anemia			
Migraine Headaches			
Gout			
Diabetes			
Birth Defects			
High Cholesterol			
Depression			
Emphysema			
Hepatitis			
HIV			

Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

SYSTEMS REVIEW

In the past month, has the newborn experienced had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss; how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Chills
- ❑ Excessive sweating

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Joint swelling
- ❑ Muscle weakness

HEAD AND NECK
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Earaches
- ❑ Recurrent ear infections
- ❑ Bleeding gums
- ❑ Mouth sores
- ❑ Nosebleeds
- ❑ Nose stuffiness
- ❑ Snoring
- ❑ Facial Pain
- ❑ Sinus pain/pressure
- ❑ Eye pain
- ❑ Eye redness
- ❑ Vision problems
- ❑ Eyes are crossed
- ❑ Mucus drainage from eyes
- ❑ Dry eyes
- ❑ Itchy eyes
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Lump or swelling in neck

SKIN
- ❑ Acne
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Change in moles
- ❑ Hair loss
- ❑ Color changes of skin color
- ❑ Changes in nails

GASTROINTESTINAL
- ❑ Decrease in appetite
- ❑ Increase in appetite
- ❑ Nausea
- ❑ Heartburn
- ❑ Abdominal pain
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Change in stools
- ❑ Blood in stools
- ❑ Black stools
- ❑ Constipation
- ❑ Rectal pain
- ❑ Rectal pain with bleeding

BLOOD
- ❑ Anemia
- ❑ Clots
- ❑ Easy bleeding
- ❑ Easy bruising tendency

HEART AND LUNGS
- ❑ Chest pain/discomfort/congestion
- ❑ Palpitations
- ❑ Heart murmur
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Leg pain with exercise
- ❑ Cough
- ❑ Coughing up sputum
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Night sweats

URINARY
- ❑ Pain during urination
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Burning during urination

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty swallowing

NEUROLOGIC/PSYCHOLOGIC
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Poor appetite
- ❑ Change in personality
- ❑ Fainting or loss of consciousness

ENDOCRINE SYMPTOMS
- ❑ Excessive thirst/fluid intake
- ❑ Excessive sweating
- ❑ Hot flashes
- ❑ Feelings of weakness
- ❑ Excessive facial or body hair

OTHER PROBLEMS
_____
_____
_____
_____
_____