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* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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**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? _____

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## 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** | | | |

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## 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
_____
_____
_____
_____
_____