HEALTH HISTORY QUESTIONNAIRE *For Newborns*

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Form completed by:	**Date:**
Name: *(Last, First, M.I.)* ☐ **M** ☐ **F**	**DOB**

BIRTH HISTORY

Prenatal history:	☐ YES ☐ NO	Gestational diabetes
	☐ YES ☐ NO	Group B Strep
	☐ YES ☐ NO	Hypertension
	☐ YES ☐ NO	Smoking during pregnancy
	☐ YES ☐ NO	Alcohol or recreational drug use during pregnancy

Birth History: ☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐ Vacuum ☐ Trauma?
Timing: ☐ On time ☐ Before 37 weeks ☐ After 42 weeks

Birth site: _____ Birth Attendant: _____

Illness: Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other, describe

DIET AND ENVIRONMENT

Feeding Plans:

☐ Breastmilk only
☐ Formula
☐ Mixed

Home Environment:

How many children in your home? _____
This child's birth order (3rd of 4 kids…) _____
What adults live with your child? _____

☐ YES ☐ NO Does your home have adequate heat, a telephone and enough food?
☐ YES ☐ NO Was your home built before 1950?
☐ YES ☐ NO Does your home have mold?
☐ YES ☐ NO Is your home safe?

FAMILY HEALTH HISTORY

Is your child adopted? …… ☐ Yes ☐ No

Have any family members had the following? If so, note relationship to child.

☐ Yes ☐ No	Deafness	☐ Yes ☐ No	Bleeding disorder
☐ Yes ☐ No	Nasal Allergies/ Eczema or Asthma	☐ Yes ☐ No	Liver or Kidney disease
☐ Yes ☐ No	Developmental or genetic disorders	☐ Yes ☐ No	Diabetes before age 50
☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Bed-wetting after age 10
☐ Yes ☐ No	Heart Disease before age 50	☐ Yes ☐ No	Epilepsy or convulsions
☐ Yes ☐ No	High Blood Pressure before age 50	☐ Yes ☐ No	Alcohol or drug abuse
☐ Yes ☐ No	Anemia	☐ Yes ☐ No	Mental illness

Reviewed on _____ Physician Signature _____