

## 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: \_\_\_\_\_