NEW PATIENT MEDICAL HISTORY
Newborns to 6 Months

Thank you for taking the time to provide the following information that is very important to your child's health.

Child's name: ______________________________ **Birth date:** ___/__/_____
Where was your child born? ______________________ **Is child adopted or fostered?** Y__ N__
Has your child *ever* previously been seen *in this practice*? Y__ N__

If you answer **YES** below, please check which **BIOLOGICAL RELATIVE** has the condition: **Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather**
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	NO	YES	If YES - Please check which biological relative						
			Mom	Dad	Sib	Maternal	Maternal	Paternal	Paternal
						Gr Mth	Gr Fth	Gr Mth	Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Type 1									
Type 2									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Mental retardation or developmental disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Obese or overweight									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

SOCIAL HISTORY	No	Yes	
Lives with both mother and father in same house			
If no, please explain custody/living arrangements			Lives with:
Does non-custodial parent have visitation rights?			
Are there siblings?			Live in same house?
Are there pets in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			
Other issues:			

IF BABY WAS BORN AT SARASOTA MEMORIAL HOSPITAL YOU MAY SKIP THE NEWBORN HISTORY QUESTIONS AND PROCEED TO THE MOTHERS PRENATAL HISTORY			
Birth Weight:________lb_____oz Birth Length:________inches			
NEWBORN HISTORY – while in hospital	**No**	**Yes**	**If YES - explain**
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Did NOT get vitamin K and / or eye prophylaxis			
Feeding: Breast milk or formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening labwork (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
Delayed passage of first bowel movement			
Heart Murmur			
Breathing problems			
Needed oxygen or help breathing			
Needed antibiotics while in nursery			
Apnea (stopping breathing)			
Needed head ultrasound			
Needed ophthalmologic (eye) exam			
Other issues:			
MOTHERS PRENATAL HISTORY	**No**	**Yes**	**If Yes - explain**
Was this an assisted conception (required help getting pregnant)?			
Was this a High Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
Did you have little or late prenatal care?			
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before birth?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Other Issues:			

What else, if anything, would you like us to know regarding your baby's health?

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: ________________________________ **Relationship to patient:** ________________

Print Name: ________________________________ **Today's Date:** ______/________/________