

Newborn History

Name:		DOB:		Phone:	
<input type="checkbox"/> Parker Adventist		<input type="checkbox"/> Sky Ridge		<input type="checkbox"/> Other:	
# of Pregnancies:		# of Live Births:		OB:	
Pregnancy Problems:					
Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section (Reason):					
Delivery Problems:					
Apgars: /		Mother's Blood Type:		Baby's Blood Type:	
Nursery Problems:					
Birth Weight: lb oz		Length:	Head Size:	Discharge Date:	Discharge Weight:
Feeding: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle					

Family Health History

	Age	Health Problems	Smoker	Height	Weight
Father (of Patient)			<input type="checkbox"/>		
Grandfather			<input type="checkbox"/>		
Grandmother			<input type="checkbox"/>		
Mother (of Patient)			<input type="checkbox"/>		
Grandfather			<input type="checkbox"/>		
Grandmother			<input type="checkbox"/>		
Sibling(s) (of Patient)			<input type="checkbox"/>		
			<input type="checkbox"/>		
			<input type="checkbox"/>		

Diseases or Problems in Family or Close Relatives, Including Infant Deaths and Birth Defects: None

Patient's Medical History – Attach Additional Documentation As Needed

Hospitalizations/surgeries (type, where, when) <input type="checkbox"/> None	
Injuries: <input type="checkbox"/> None	
Major Illnesses or Chronic Problems: <input type="checkbox"/> None	
Allergies: <input type="checkbox"/> None	
Daily Medications: <input type="checkbox"/> None	
Development: <input type="checkbox"/> Normal <input type="checkbox"/> Delayed / What Areas:	
Immunization Dates: <input type="checkbox"/> Record from previous medical provider attached	
DaPT/DPT/DT	Polio
Hep B	Rotavirus
Pneumococcal (Pevnar)	Chickenpox (Varivax)
Gardasil	Meningococcal

Systems Review

(Answer "Yes" if these are chronic or ongoing problems)

	Yes	No		Yes	No		Yes	No		Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Birthmarks	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Strep Throats	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Appetite Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
									Other	<input type="checkbox"/>	<input type="checkbox"/>