

NEW PATIENT MEDICAL HISTORY – Newborn to 6 months of age

THIS FORM MUST BE COMPLETED AND RETURNED BEFORE FIRST VISIT

WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER ANY VACCINES –

If immunizations are NOT up-to-date, provide reason: _____

The following is **very important** to your child's health. Please complete it **accurately** and **completely**.

Child's name: _____ **Birth date:** ____/____/____

Where was your child born? _____ Is child adopted or fostered? Y___ N___

Has your child **ever** previously been seen by any of the doctors in this practice? Y___ N___

In this **FAMILY** medical history – if you answer **YES** – please check off which **BIOLOGICAL RELATIVE** has the condition

Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather

List or explain condition if possible.

[illegible]

Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

SOCIAL HISTORY	No	Yes	
Lives with both mother and father in same house			
Non-intact home - give custody status			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:			

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 lab work (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:			
MOTHER'S PRENATAL HISTORY	No	Yes	If Yes - explain
Was this an assisted conception (had to have 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 born?			
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:			

Is there anything else regarding your child's health that you think we should know that has not already been asked?

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: ____/____/____

Office Use Only
 Provider Review: _____ Date: _____