Shoreline Pediatrics, PLC

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Newborn Patient Medical Information

Patient Name______________________________ **Sex** __Male __Female

Birth Date___________ **Birth Weight**___lbs ____ozs. **Length**_____inches **Head Circumference** ______cm

Place of Birth ___Muskegon General ___Hackley ___Other ________________ **Delivering Dr.**__________

Type of Delivery ___Vaginal ___C-Section Why?______________________________

Did you have prenatal care? yes/no How long was your baby in the hospital after birth? ____ day(s)

Birth premature / on time / overdue Who many weeks early or late?____

Problems at Delivery or in Nursery:

___Infection ___Feeding Problems ___Apnea ___Jaundice ___Other What?______________________

Pregnancy Problems: __Diabetes ___High Blood Pressure ___Infection? Type___________

___Others What?:____

Maternal Drugs (during Pregnancy)__Smoking ___Packs/day ___Alcohol ___Drinks/Week

___Prescription Drugs What? When?

___Other Drugs? What? When?

Feedings

___Breast How Frequently? Every____Hrs. How many mins?________

___Formula Brand______________ _____ozs. every ____hrs.

Has Your Baby Tried Any Other Formulas? yes /no What Brand? What Happened?

Any spitting up? yes /no How often? ___ times per day

How many wet diapers per day? _____

How many stools/day? ____ soft or hard?_____

Family History

Are mother and father of this child married? ____ Living together?_____

If child does not live with mother and father, please state living conditions, visitation etc.

____

Who is the main caregiver to this child if other than mother? ____________________________

Will he/she be in daycare? yes/no How often? ______

Is he/she ever exposed to tobacco smoke ? yes/no Where?_______________________________

PLEASE COMPLETE BACK OF FORM

Who lives at home with this child? (Mother refers to mother of the child, etc)

Relationship: ________________ **Age:**_____ **Health problems:** ______________________________

________________ _____ ______________________________

________________ _____ ______________________________

________________ _____ ______________________________

List any parents, brothers or sisters who don't live with this child:

Relationship: ________________ **Age:**_____ **Health problems:** ______________________________

________________ _____ ______________________________

________________ _____ ______________________________

	Illness	**Child**	**Mother**	**Father**	**Brother**	**Sister**	**Other relatives**
1	Anemia or other blood problems	☐	☐	☐	☐	☐	________
2	Bleeding Tendencies	☐	☐	☐	☐	☐	________
3	Sickle Cell disease or trait	☐	☐	☐	☐	☐	________
4	Asthma	☐	☐	☐	☐	☐	________
5	Hay Fever	☐	☐	☐	☐	☐	________
6	Eczema or skin problems	☐	☐	☐	☐	☐	________
7	Birth Defects	☐	☐	☐	☐	☐	________
8	Cancer	☐	☐	☐	☐	☐	________
9	Chromosomal Abnormality	☐	☐	☐	☐	☐	________
10	Cystic Fibrosis/lung disease	☐	☐	☐	☐	☐	________
11	Diabetes	☐	☐	☐	☐	☐	________
12	Elevated Cholesterol levels	☐	☐	☐	☐	☐	________
13	Epilepsy, seizures	☐	☐	☐	☐	☐	________
14	Hearing problems	☐	☐	☐	☐	☐	________
15	Hepatitis	☐	☐	☐	☐	☐	________
16	Heart Disease or Heart Attacks	☐	☐	☐	☐	☐	________
17	High blood pressure	☐	☐	☐	☐	☐	________
18	Immune problems	☐	☐	☐	☐	☐	________
19	Repeated infections	☐	☐	☐	☐	☐	________
20	Metabolic Problems	☐	☐	☐	☐	☐	________
21	Kidney infections or disease	☐	☐	☐	☐	☐	________
22	Mental Disease or Disorder	☐	☐	☐	☐	☐	________
23	Mental Retardation	☐	☐	☐	☐	☐	________
24	Muscular Dystrophy	☐	☐	☐	☐	☐	________
25	Rheumatoid Arthritis	☐	☐	☐	☐	☐	________
26	Sexually transmitted diseases	☐	☐	☐	☐	☐	________
27	Thyroid Disease	☐	☐	☐	☐	☐	________
28	Tuberculosis	☐	☐	☐	☐	☐	________
29	Vision or eye problems	☐	☐	☐	☐	☐	________
30	Other significant illnesses	☐	☐	☐	☐	☐	________

Additional details on above by number:____

____

Do you have any special concerns about your newborn?____

____

Signature:____ Date:________________

Relationship to child if other than mother :______________________________

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