Witham Health Services Pediatrics – Newborn History Form

Child's Name:		DOB:	Gender:	M F
Phone #1:	Phone #2:	Language (pr	imary):	
Address:		City:	State:	Zip:
Other Pacific Islander	ve Asian White Prefer not to	<u> </u>	acific Islander	
Ethnicity: (choose one) Hispanic or Latino	Not Hispanic or Latino	Prefer not to answ	er	
Parent / Legal Guardian #1 Name: Relationship to Patient: Employer:		Email Address:		
Parent / Legal Guardian #2				
Name:		SS#	DOB:	
Address (if different):				
Relationship to Patient:				
Employer:				
Emergency Contact (Other than p	arent/legal guardian)			
Name:	,	Relationship to Patient:		
Phone #1:				
Insurance				
Insurance Name:		Policy Holder:		
NOTE: If you have secon	ndary insurance please in	nform front office		
<u>Pharmacy</u>				
Pharmacy Name:		City:		
All information above is correct an				
Printed Name		re		

Relationship to Patient Name (first and last) Ad	ie Health Problems	Lives with patient (Y/N)
Please list all family members (parents and all siblings). Include a	nyone who lives in the same househ	old with the patient.
<u>Family</u>		
How many living children does birth mother have?		
Hon many times has birth mother been pregnant?		
Did birth mother use alcohol, tobacco, or other drugs during this p	oregnancy? Yes No	
Has birth mother ever had gonorrhea or chlamydia infection?		
Did birth mother take any medications during pregnancy? Please	include prescription and over the cou	unter medications:
Were there any problems during the pregnancy (diabetes, high blo	ood pressure, infections)?	
Maternal Pregnancy History		
If so, where?		
Did your baby require admission to a neonatal intensive care unit?	? Yes No	
Any problems while in the nursery (jaundice, feeding problems, in	fections)?	
Were there any problems with the delivery?		
If Yes, how early?		
Was the baby born more than a week before the due date (before	39 weeks)? Yes No	
Birth Place:	Birth Weight:	
Is your child adopted? Yes No Religion:		
Birth History		
Date of Birth: Date Form Completed:		
Baby's Name:		

Relationship to Patient	Name (first and last)	Age	Health Problems	Lives with patient (Y/N)
Mother				
Father				

Family History

nas anyoi	ne nad the following he	aitii probieii	is? (include th	le baby's parents, aunts, uncles, cousins, and	granuparen	lS.)
<i>,</i> E C C E <i>,</i> H	Asthma Allergies Eczema Diabetes Cancer Bleeding Problems Anemia High Blood Pressure Heart Attack	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	No	Seizures (convulsions) Birth Defects Death in Infancy Alcohol/Drug Problems Mental Retardation Thyroid Disease Mental or Emotional Problems Suicide or Suicide Attempt	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes	No No No No No No No No
Reviewed by Physician			 Date			