McKinney Pediatrics

Date: _____

NEWBORN Health History

Please fill out this form as completely and accurately as you can. If you are unsure of how to answer a certain item, just circle it and we will be happy to discuss it with you. All information is confidential.

Child's Name: _____ Date of Birth: _____ Male ____ Female _____

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Place of birth: _____

Birth Weight: _____ Length: _____

Delivery (Please circle all that apply):

On Time Premature Late Normal Induced Prolonged Breech C-section

Please describe any other complications (if any): _____

Did your child have: Breathing problems Jaundice Transfusion

During pregnancy did the mother experience any of the following: (Please check all that apply)

	Alcohol Use		Anemia		Diabetes
	Edema/Swelling		High blood pressure		Hepatitis
	German Measles		Protein in urine		Venereal disease
	Fever		Urinary tract infection		Exposure to chemicals/radiation
	Tobacco use		Non-prescription drug use		Prescription drug use
	Controlled substance drug use		Other:		

Please circle any condition that any of the child's blood relatives have had and indicate the relationship to child:

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Alcoholism		HIV/AIDS	
Anemia		Kidney Disease	
Asthma/Allergies		Lung Disease	
Autism		Mental Disease/disorder	
Birth Defects		Muscular disorder	
Bone/Joint disorders		Rheumatic fever	
Cancer		Seizures/Convulsions	
Diabetes		Sickle cell disease	
Epilepsy		Skin disease	
Genetic Defects		Stroke	
Heart Disease		Thyroid disorder	
Hemophilia			
High Blood Pressure		Other:	

Signature: _____ Relationship to patient: _____