# Newborn Information Form

Brent K. Eberhard, M.D.

| Child's Name | Nickname | DOB | M F |
|---|---|---|---|
| Mother's Name Occupation | Father's Name Occupation | | |

## Birth History

Birth Weight ____________ Gestational Age ____________________

Hospital ________________________________________________

Did mother have any problems during pregnancy?

Explain ________________________________________________

Did mother experience problems during labor and delivery?

Explain ________________________________________________

What medications were taken during pregnancy?____________________

Any Drugs/Alcohol/Tobacco?

Was the delivery Vaginal Cesarean

If Cesarean, why? ____________________________________

Did your baby have any problems right after birth?

Explain ____________________________________________

Any Jaundice?

Explain

Group B Strep Positive Negative

If positive, antibiotics given? Doses? __________

Hep B Given? Blood Type __________

Was initial feeding Breast Milk? Formula?

Passed Hearing Screen

## Household Information - Please List All Those Living in the Child's Home

| Name | Relationship to Child | Date of Birth |
|---|---|---|
| | | |
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| | | |

Smoke & Carbon Monoxide Detectors? ______________________

Smokers in Household? ______________________

Pets in Household? ______________________

Child Care: ______________________

## Family Medical History (Parents, Siblings, Grandparents)

Have any Family Members Had The Following:

| | | |
|---|---|---|
| Alcohol/Drug Abuse | Who? ______________ | Comments ______________ |
| Allergies | Who? ______________ | Comments ______________ |
| Asthma | Who? ______________ | Comments ______________ |
| Blood Disease | Who? ______________ | Comments ______________ |
| Cancer | Who? ______________ | Comments ______________ |
| Cholesterol | Who? ______________ | Comments ______________ |
| Diabetes | Who? ______________ | Comments ______________ |
| Heart | Who? ______________ | Comments ______________ |
| Hypertension | Who? ______________ | Comments ______________ |
| Mental Health Problems | Who? ______________ | Comments ______________ |
| Ophthalmology | Who? ______________ | Comments ______________ |
| Skin/Eczema | Who? ______________ | Comments ______________ |
| Stomach Problems | Who? ______________ | Comments ______________ |
| Thyroid | Who? ______________ | Comments ______________ |
| Urinary Problems | Who? ______________ | Comments ______________ |

Additional Family History/Comments: ______________________________________