NEWBORN/INFANT HISTORY QUESTIONNAIRE (<12 Months)

Child's Name:_____ Nickname:_____ Birth date:_____

Address:_____ City:_____ Zip:_____

Did mother take any medications, drugs, alcohol or smoke during pregnancy? NO YES

If yes, please explain:_____

Were there any problems with the pregnancy? NO YES

If yes, please explain:_____

Was the delivery_____ vaginal/Cesarean? _____ forceps/ vacuum?

Were there any problems with the birth? NO YES

If yes, please explain:_____

Baby's birth weight:_____ Length_____

Has your baby had problems since birth? NO YES

If yes, please explain:_____

Mother's blood type (if known): _____ Baby's blood type (if known):_____

If you are breast feeding, how often does your baby eat?_____

If you are bottle feeding, what formula?_____ How much and how often?_____

Are you having any problems with feeding? NO YES

If yes, please explain:_____

Does your baby have any elimination problems? NO YES

If yes, please explain:_____

Does your baby have any sleeping problems? NO YES

If yes, please explain:_____

Does your baby seem to be developing normally? NO YES

If yes, please explain:_____

Please circle any medical problems that run in the child's family:

anemia	depression	hay fever	mental retardation
allergies	diabetes	heart problems	seizures
asthma	early deaths	high blood pressure	sickle cell disease
birth defects	eczema	kidney problems	thyroid disease
cancer	genetic problems	liver problems	tuberculosis

If any above are circled, please describe:

_____

_____

Your name:_____ Date:_____

Reviewed date:_____ by:_____, M.D.