Newborn Record

Hospital Information DoB ___/___/___ E.D.C.___/___/___ Hospital_____ Obs._____

Insurance Co._____ Policy #_____

Family Information Child's Name_____ Sex: ☐M ☐F

_____
Address City, State, Zip

Mother's Name_____ Age _____ Home Phone _____

Mother's Employer_____ Work Phone _____

Father's Name_____ Home Phone _____

Father's Employer_____ Work Phone _____

FamilyMedical History

Check if members of the child's family (parents (P), siblings (S), grandparents (G), aunts or uncles (A or U) have had the following illnesses or problems. List appropriate initial after each.

- ☐ Allergies_____
- ☐ Allergy shots_____
- ☐ Drug allergies_____
- ☐ Asthma_____
- ☐ Eczema_____
- ☐ Respiratory infections_____
- ☐ Ear tubes_____
- ☐ Anemia or blood disorders_____
- ☐ Stomach or intestinal problems_____
- ☐ Diabetes_____
- ☐ Growth problems_____
- ☐ Seizures or Convulsions_____
- ☐ Cholesterol problems_____
- ☐ High Blood Pressure_____
- ☐ Heart Attack or Stroke before age 55_____
- ☐ Cancer_____
- ☐ Hereditary problems_____
- ☐ Emotional or Behavioral problems_____
- ☐ Alcohol or Drug problems_____
- ☐ Did mother use tobacco, alcohol, or recreational drugs during pregnancy?

_____

_____

- ☐ Did mother have any health problems during pregnancy?

_____

_____

_____

_____

HX Reviewed By/Date_____

Maternal History

Gr_____ Para_____ Ab_____ Blood Type_____

Pregnancy: ☐nl ☐abn ☐Term ☐Preterm _____

Labor: ☐nl ☐abn Delivery: ☐Vaginal ☐C-Section _____

Problems: _____

_____

_____

_____

Prenatal Screening

Gr. B Strep ☐neg ☐pos Serology test ☐neg ☐pos

Hepatitis B ☐neg ☐pos Rubella Immune ☐Yes ☐No

Newborn History

Date of examination ___/___/___ Date of discharge ___/___/___

BW_____ L_____ HC_____ Chest C _____ Apgar_____

Blood Type_____ Coombs_____ Hearing: ☐nl ☐abn

Feedings: ☐ Breast ☐ Formula _____

Examination: ☐nl ☐abn_____

Problems:_____

_____

_____

_____

_____

Metabolic Screen: ☐ Yes ☐ No Date___/___/___

DAILY WEIGHTS				DISCH. WT.

DATE	HCT	GLUCOSE	BILIRUBIN DIRECT	BILIRUBIN TOTAL

Hepatitis B Vaccine: ☐ Yes ☐ No Date___/___/___

HBIG: ☐ Yes ☐ No _____

Date of follow-up examination _____

Provider Signature_____

Name _____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Pregnancy History

Was pregnancy… ☐ Full term ☐ Premature (# of weeks_____)

Were there any complications during pregnancy? ☐ Yes ☐ No

Were there any complications during labor? ☐ Yes ☐ No

Were there any complications during delivery? ☐ Yes ☐ No

Birth History

Birth weight _____ Hospital discharge weight _____ Apgar _____

Did your baby have any complications after delivery? ☐ Yes ☐ No

Neonatal History

Are you concerned about your baby's…	YES	NO
1. feedings ☐ Breast ☐ Formula _____	☐	☐
2. excessive spitting or vomiting	☐	☐
3. bowel movements	☐	☐
4. straining with stools	☐	☐
5. straining or crying with voiding	☐	☐
6. nasal stuffiness	☐	☐
7. skin color or skin rashes (circle)	☐	☐
8. excessive crying	☐	☐
9. lack of response to your face or voice	☐	☐
10. lack of response to a loud noise	☐	☐
11. body movement, especially extremities	☐	☐
12 sleep habits	☐	☐
13. Does he/she sleep on back?	☐	☐
14. Is your child exposed to cigarette smoke?	☐	☐
15. Do you have any help with the baby?	☐	☐
16. Are you getting enough rest?	☐	☐
17. Have you been sad, depressed or crying excessively?	☐	☐
18. Does your child ride in a rear-facing safety seat?	☐	☐
19. Do you know infant CPR?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

_____ _____

Parent's Signature Date

Parent's section reviewed by_____

History

☐ Previous concerns, consults and procedures reviewed

Metabolic Screening ☐ Nl. ☐ Abn. Hearing Screening ☐ Nl. ☐ Abn.

(Interval: ☐ No Change) Concerns _____

Current Medications _____

Drug Allergies ☐ Yes ☐ No _____

Past / Social / Family History (Interval: ☐ No Change)

Provider Comments _____

Anticipatory Guidance

General	*Nutrition*	*Injury Prevention*
☐ Growth /Dev.	☐ Breast	☐ Car seat
☐ Stools/Urine	☐ Formula	☐ Falls
☐ Sleep (on back)	☐ Solids (4-6 Mo.)	☐ No strings around neck
☐ Sleep in bed alone	☐ Vitamins	☐ No shaking
☐ Crib/Mattress	☐ No honey	☐ Burns-hot water
☐ Pacifier use	☐ No bottle prop	☐ Smoke alarms
☐ Ed. Handouts	☐ No microwave	☐ Gun safety