MiKiDS PEDIATRICS

NEW BABY FORM

Patient Name:

Last_____ First_____ MI_____ Nickname _____

DOB_____/_____/_____ Place of birth_____

Birth Weight_____ Discharge Weight_____ Birth Length_____

Gestational age at delivery_____

Delivery method: ❑ vaginal ❑ c-section

Number of Previous Pregnancies_____ Deliveries_____

Pregnancy Complications_____

Delivery Complications_____

Breech: ❑ yes ❑ no

Concerns in Newborn Nursery_____

Passed Hearing Screen: ❑ yes ❑ no

Exposure to any of the following during pregnancy?

❑ tobacco ❑ alcohol ❑ medications ❑ illegal drugs ❑ infections

Please List:_____

Feeding History: ❑ breast ❑ bottle

Previous history of post partum depression: ❑ yes ❑ no

FAMILY HISTORY

Relationship	Alcohol Abuse	Allergy - severe	Anemia	Asthma	Cancer	Diabetes	Drug Abuse	Heart Attack	Hypertension	Kidney Disease	Mental Illness	Mental Retardation	Rashes/ Skin Problems	Seizures	Sickle Cell Anemia	Hearing Loss	High Cholestrol	Heart Disease	Tuberculosis	ADHD/ADD	Learning Disabilities	Vision Loss	Birth Defects
Mother																							
Father																							
Sister																							
Brother																							
Maternal Aunt																							
Maternal Uncle																							
Paternal Aunt																							
Paternal Uncle																							
Maternal Grandma																							
Maternal Grandpa																							
Paternal Grandma																							
Paternal Grandpa																							