



PATIENT NAME _____ AGE _____ SEX _____ BIRTH DATE _____ DATE OF EXAM _____

Welcome to our office with your new baby. Please answer these questions and provide any further information in the column at the right.

(Please explain right-hand column answers here.)

- | | |
|---|-----------|
| 1. Are you and your baby doing well? | Yes No |
| 2. Where was your baby born? (Please circle and give name)
Home Hospital _____
Birth wt. _____ Length _____ APGAR _____ | |
| 3. Did you have any problems with: <input type="checkbox"/> pregnancy, labor or delivery
<input type="checkbox"/> prematurity <input type="checkbox"/> postmaturity <input type="checkbox"/> first week of life
<input type="checkbox"/> prolonged hospitalization | No Yes |
| 4. Is your baby eating well 7 to 10 times daily? <input type="checkbox"/> breast <input type="checkbox"/> bottle | Yes No |
| 5. Is your baby circumcised? Are there any problems with that? | No Yes |
| 6. Has your baby had any problem with: <input type="checkbox"/> Choking <input type="checkbox"/> Breathing
<input type="checkbox"/> Eyes <input type="checkbox"/> Skin <input type="checkbox"/> Circumcision <input type="checkbox"/> Jaundice <input type="checkbox"/> Bowels
<input type="checkbox"/> Urine <input type="checkbox"/> Umbilical Cord | No Yes |
| 7. Are the members of the family in good health?
Age of mother _____ Ages of sisters _____
Age of father _____ Ages of brothers _____ | Yes No |
| 8. Is there any family history of: <input type="checkbox"/> tuberculosis <input type="checkbox"/> heart disease
<input type="checkbox"/> allergies <input type="checkbox"/> diabetes <input type="checkbox"/> cystic fibrosis <input type="checkbox"/> high blood pressure
<input type="checkbox"/> asthma <input type="checkbox"/> epilepsy <input type="checkbox"/> kidney disease <input type="checkbox"/> high cholesterol
<input type="checkbox"/> eczema <input type="checkbox"/> cancer <input type="checkbox"/> bleeders <input type="checkbox"/> stroke before age 55
<input type="checkbox"/> hay fever <input type="checkbox"/> mental retardation | No Yes |
| 9. Do you have pets or livestock? Types: _____ | No Yes |
| 10. Have there been any major changes or stresses in the family? | No Yes |
| 11. Mother's Occupation: _____ | |
| 12. Father's Occupation: _____ | |
| 13. Does your baby go to a day care or a babysitter? | No Yes |
| 14. Does s/he have any unusual or bothersome behaviors? | No Yes |
| 15. Do you always use an approved car seat, properly installed, for your baby's car trips? | Yes No |
| 16. Do you have a working smoke alarm? | Yes No |
| 17. Have you had formal CPR and First Aid training? | Yes No |
| 18. Is your baby exposed to tobacco smoke at home or in day care? | No Yes |
| 19. Does your baby: <input type="checkbox"/> watch you <input type="checkbox"/> respond to sounds
<input type="checkbox"/> turn head <input type="checkbox"/> move all arms and legs | Yes No |
| 20. Are there any special questions you would like to ask today?
1)
2)
3) | No Yes |