Cornerstone Pediatrics

Newborn Health History Form 0 to 4 Weeks

Name____ *Male / Female* DOB ____ / ____ / ____

Previous Last Name (if different than above): ____

Mother's Name: _____________________________ DOB: ____/____/____ Occupation: __________________

Father's Name: _____________________________ DOB: ____/____/____ Occupation: __________________

Please list all people in your household other than the patient:

Name	Date of Birth	Relation to Patient

Birth History

Place of Birth: ____ Birth Weight: ____________________

During pregnancy did mother use alcohol or street drugs? Yes ☐ No ☐

Were there any problems during pregnancy or delivery? Yes ☐ No ☐

Was baby born prematurely (less than 37 weeks)? Yes ☐ No ☐

How long was baby in the hospital?

Family History

Has a blood relative had any of the following? *If Yes, circle condition and explain:*

Allergies/Asthma / Lung disease / Tuberculosis Yes ☐ No ☐

Birth defect Yes ☐ No ☐

Cancer Yes ☐ No ☐

Diabetes / Kidney disease/ Thyroid disease	Yes ☐	No ☐	
Drug or Alcohol use / abuse	Yes ☐	No ☐	
Heart attack /disease/ high blood pressure/high cholesterol	Yes ☐	No ☐	
Mental Illness / Depression	Yes ☐	No ☐	
Obesity / Overweight	Yes ☐	No ☐	
Seizures / Epilepsy	Yes ☐	No ☐	
Have any of the child's siblings died?	Yes ☐	No ☐	
Any family member under the age of 50 died suddenly of causes other than accident or violence?	Yes ☐	No ☐	

Social History

Are this child's parents married?	Yes ☐	No ☐	
Do you attend a church and have a religious preference?	Yes ☐	No ☐	If yes, what?
Will child go to day care or a baby sitter regularly?	Yes ☐	No ☐	

Completed by (Parent / Guardian's signature) **Date**

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