

NEW BORN QUESTIONNAIRE Completed by: _____ Relation: _____

Name: _____ Date of Birth: _____ Is Baby Adopted? _____

FAMILY PROFILE

- Parents - Married Separated Divorced
 Not Married

Mother's Name: _____
 Social Security # _____
 D.O.B.: _____ Highest school grade: _____
 Occupation: _____ Employer: _____
 Health: _____

Father's Name: _____
 Social Security # _____
 D.O.B.: _____ Highest school grade: _____
 Occupation: _____ Employer: _____
 Health: _____

SAFETY/ENVIRONMENT

1. Name of hospital of birth with city and state _____
2. Previous primary care name and address _____
3. Do you live in a private house, apartment,
 mobile home, other?
4. Do you know the hottest temperature of the water in your pipes? Y N
5. Is there a working smoke alarm on each floor in the house? Y N
6. Does your child always use a car seat/ seatbelt when riding a car? Y N
7. Are there any smokers in the household? N Y
8. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) N Y
9. Does your home have a pool? Y N
10. Are there firearms in your home? N Y

I hereby give permission for my child to receive medical care in the case of an emergency in the event I can't be reached.

Signature of Parent or Legal Guardian _____

Date _____ / _____ / _____

SIBLINGS

List child's brothers and sisters:

Name:	D.O.B.
1. _____	_____
Health: _____	_____
2. _____	_____
Health: _____	_____
3. _____	_____
Health: _____	_____
4. _____	_____
Health: _____	_____
5. _____	_____
Health: _____	_____
6. _____	_____
Health: _____	_____

Have any of your children died? Y N

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems - use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

- Anemia/Blood Dis _____
- Asthma/Allergies _____
- Intellectual Disability _____
- Drug Problem _____
- Alcoholism _____
- Cancer _____
- Sudden Infant Death _____
- Cystic Fibrosis _____
- Musc. Dystrophy _____
- Tuberculosis _____
- Arthritis/Lupus _____
- Epilepsy/Seizures _____
- Early Diabetes _____
- Early Deafness _____
- Birth Defects _____
- AIDS _____
- High Blood Pressure _____
- High Cholesterol _____
- Migraines _____
- Heart Disease _____
- Kidney Disease _____
- Emotional Problems _____
- Thyroid Disease _____
- Inherited Disease _____
- Other _____