NEWBORN QUESTIONNAIRE Completed by: _____ Relation: _____

Baby's Name: _____ Date of Birth: _____ Baby Adopted? _____

Hospital (inc. city/state): _____ Name of Delivery OB: _____

Previous Primary Care name and address: _____

FAMILY PROFILE

Parents: Married? _____ Separated? _____ Divorced? _____
Not Married? _____
Mother's Name: _____
DOB: _____ Highest school grade: _____
Occupation: _____ Employer: _____
Health: _____
Father's Name: _____
DOB: _____ Highest school grade: _____
Occupation: _____ Employer: _____
Health: _____

SAFETY/ENVIRONMENT (please circle)

Do you live in a private house/apartment/mobile home/other?

Do you know the hottest temperature of the water in your pipes?
YES/NO
      Set your water heater thermostat so that the hottest
      temperature at the faucet is 120° F to help to avoid scald
      burns.

Is there a working smoke alarm on each floor in the house?
YES/NO

Does your child always use a car/seat/seatbelt in car? YES/NO

Are there smokers in the household? YES/NO

Are there any problems with the condition of your home?
PEELING PAINT/INSECTS/RATS/MICE

Does your house have a pool? YES/NO

Are there firearms in your home? YES/NO

_____ _____/_____/_____
Signature of Parent/Legal Guardian   Date

SIBLINGS

List the child's brothers and sisters:
NAME: DOB:
_____ _____/_____/_____

NAME: DOB:
_____ _____/_____/_____

NAME: DOB:
_____ _____/_____/_____

NAME: DOB:
_____ _____/_____/_____

NAME: DOB:
_____ _____/_____/_____

NAME: DOB:
_____ _____/_____/_____

Have any of your children died? YES/NO

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems – use abbreviation (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 _____