**GVSU Family Health Center**

**Newborn History**

**Is your child** Biological Adopted Foster Guardian

**Prenatal Care** Yes No

**Maternal Problems During Pregnancy**

Prescription Medications Diabetes

Street Drugs High Blood Pressure

Smoking STD

Alcohol Use Infections

Other

**Where was your baby born?** Home Hospital, what hospital\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delivery** Vaginal C-Section, why:

fetal distress repeat failure to progress other

**Complications in the Nursery** None

Infection Birth Defects

Feeding Issues Heart Murmur/Defects

Apnea Breathing Problems

Jaundice Kidney Defects

Surgery Sickle Cell Trait/Disease

Chromosome Abnormality Seizures

Metabolic Problems Other

How long did your baby stay in the hospital after birth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Gestation/What was your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feed your baby with Bottle Breast

If you breast feed How often do you breast feed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you breast feed each feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you bottle feed What formula do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much does your baby take at a feeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How far apart are the feedings?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feed your baby anything other than breast milk or formula? Yes No

Does your baby take any medications? Yes No

Does your baby live with anyone or visit anyone regularly who uses tobacco? Yes No

**Mom, over the past 2 weeks, how often have you been bothered with:**

Little interest or pleasure in doing things?

Not at All Several Days More than ½ the Days Nearly every day

Feeling down, depressed, or hopeless?

Not at All Several Days More than ½ the Days Nearly every day

**GVSU Family HEalth Center**

**Newborn/Pediatric Social History**

Who lives in the household with the child?

Are mother and father? married, living together, never married, divorced, separated

Who is the main caregiver for this child?

Does your child attend day care? Yes/no; if so, how many hours/week

Does mom work? Yes/no; if so, full time or part time

Does dad work? Yes/no; if so, full time or part time

Does your child use a car seat regularly? Yes/no

If your child is under 2 years of age, is he/she in a rear facing car seat? Yes/no

If your child is between 2 and 4 years, is he/she in a forward facing car seat with a 5 point harness? Yes/no

If your child is over 4 years of age and under 57 inches, is he/she in a booster seat? Yes/no

If your child is under the age of 13 year:

Does he/she ride in the front seat? Yes/no

Does he/she wear a seatbelt at all time while riding in a car? Yes/no

Do you have a smoke detector in your house? Yes/no

Do you have a carbon monoxide detector in your house? Yes/no

Do you have any guns in your house? Yes/no; if yes, are the guns locked up and unloaded? Yes/no

Are there any pets in the house? Yes/no

What kind of water do you have? well water city water

**GVSU Family HEalth Center**

**Family Medical History**

Alcohol abuse? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/Hay fever? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma/Wheezing? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADD/ADHD? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth defects? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding Disorder? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer? Yes/No What kind?­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chromosome Abnormality? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cystic Fibrosis/Lung disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug abuse? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy/Seizures? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Problems? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease/Heart Attacks (before age 55) Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis/Liver disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIV/AIDS/Immune Problems? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental illness/depression? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Retardation? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscular Dystrophy? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rheumatoid arthritis? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually transmitted diseases? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sickle Cell? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid disease? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision or eye problems? Yes/No Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any family member had an unexplained, unexpected death before age 50? Yes/No