# NEWBORN/INFANT HISTORY QUESTIONNAIRE (<12 Months)

Child's Name:_____ Nickname:_____ Birth date:_____

Address:_____ City:_____ Zip:_____

Did mother take any medications, drugs, alcohol or smoke during pregnancy? NO YES

If yes, please explain:_____

Were there any problems with the pregnancy? NO YES

If yes, please explain:_____

Was the delivery_____ vaginal/Cesarean? _____ forceps/ vacuum?

Were there any problems with the birth? NO YES

If yes, please explain:_____

Baby's birth weight:_____ Length_____

Has your baby had problems since birth? NO YES

If yes, please explain:_____

Mother's blood type (if known): _____ Baby's blood type (if known):_____

If you are breast feeding, how often does your baby eat?_____

If you are bottle feeding, what formula?_____ How much and how often?_____

Are you having any problems with feeding? NO YES

If yes, please explain:_____

Does your baby have any elimination problems? NO YES

If yes, please explain:_____

Does your baby have any sleeping problems? NO YES

If yes, please explain:_____

Does your baby seem to be developing normally? NO YES

If yes, please explain:_____

Please circle any medical problems that run in the child's family:

| | | | |
|---|---|---|---|
| anemia | depression | hay fever | mental retardation |
| allergies | diabetes | heart problems | seizures |
| asthma | early deaths | high blood pressure | sickle cell disease |
| birth defects | eczema | kidney problems | thyroid disease |
| cancer | genetic problems | liver problems | tuberculosis |

If any above are circled, please describe:

_____

_____

Your name:_____ Date:_____

Reviewed date:_____ by:_____, M.D.