MONTEREY PENINSULA
pediatric
MEDICAL GROUP

2 Upper Ragsdale Drive
Suite B-210
Monterey, CA 93940

Newborn Health History Form

Patients Name_____ **Today's Date**_____
Birthday:_____

Your relationship to child:_____

Present health concerns:
_____
_____
_____

PREGNANCY & BIRTH
Where was your child born?_____
Is the child yours by: □ Birth □ Adoption
□ Stepchild □ Other:_____
Please indicate any medical problems during pregnancy □ None
□ Specify:_____
Delivery by □ Vaginal birth □ Caesarean
If Caesarean, why?_____
Birth weight: _____ Birth length:_____
APGAR score 1 min_____ 5 min._____
Please indicate any medical problems during the baby's newborn period
□ None
(If premature, how early?)_____

_____
Other problems:
_____

NUTRITION & FEEDING
Is your child breastfed? □ No □ Yes

Has your child had any unusual feeding problems? □No □Yes

If yes, specify:
_____

SLEEP
Hours per night_____
Naps (number & length) _____
Any sleep problems? _____

FAMILY HISTORY
Please indicate any deaths of your immediate family members_____
_____
_____

FAMILY HISTORY (Continued)
Please circle any family history of the following conditions and indicate family members affected (parent, sibling, grandparent, aunt or uncle)

Alcoholism/drug abuse_____
High cholesterol/High blood pressure_____
Cancer, specify type_____
Heart disease or stroke before age 60_____
Bleeding or clotting disorder_____

SOCIAL HISTORY

Who lives at home?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are your child's parents:
□ Married □ Unmarried
□ Separated □ Divorced
If divorced or separated, when?
_____
Mother's Occupation_____
Mother's Employer _____
Father's Occupation_____
Father's Employer_____

Child care situation □ Parents □ Others
(specify who and how often)_____
_____
Is violence at home a concern? □ No □ Yes
Are there guns in the home? □ No □ Yes