

**PEDIATRIC GEMS, PC**  
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## NEWBORN QUESTIONNAIRE

### INITIAL HISTORY QUESTIONNAIRE

Name of Patient: \_\_\_\_\_ D.O.B. \_\_\_\_\_ M \_\_\_ F \_\_\_  
Name of Mother: \_\_\_\_\_ Father: \_\_\_\_\_  
Date Completed: \_\_\_\_\_

**Medications:** include all prescription, nonprescription, maintenance & as needed meds

Name \_\_\_\_\_ Dose \_\_\_\_\_ How often ? \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Immunizations:** Was Hepatitis B given in Hospital? \_\_\_yes \_\_\_no

**Hearing Test:** \_\_\_Pass \_\_\_Failed

### Birth History:

Born where \_\_\_\_\_ Gestational Age (weeks) \_\_\_\_\_

Type of Delivery \_\_\_\_\_ emergency? \_\_\_\_\_ Forceps or Vacuum? yes \_\_\_\_\_ no \_\_\_\_\_

Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Head Circumference \_\_\_\_\_

Feeding, breast or bottle? \_\_\_\_\_

Group B Strep Positive or Negative (Circle One) Antibiotics Given? \_\_\_\_\_

Mother's Pregnancy Health:

Abnormal Labs/Tests? \_\_\_\_\_

(Yes/No) High Blood Pressure \_\_\_ Diabetes \_\_\_ If so, did this condition exist prior to pregnancy \_\_\_

Smoked \_\_\_ Drank Alcohol \_\_\_ Drugs \_\_\_

Birth Complications \_\_\_\_\_

Problems during the hospital course \_\_\_\_\_

**History of Surgeries at Birth:** No \_\_\_ Yes \_\_\_ *If yes, please give details.*

Date \_\_\_\_\_ Surgeon \_\_\_\_\_ Location \_\_\_\_\_

Procedure Performed \_\_\_\_\_

**Family Medical History** indicate who in relationship to child has the following problems...

Unremarkable (Please select this if all answers below are no) \_\_\_\_\_

Gastrointestinal Problems \_\_\_\_\_ High Cholesterol \_\_\_\_\_

Deafness \_\_\_\_\_ Anemia \_\_\_\_\_

Nasal Allergies \_\_\_\_\_ Liver Disease \_\_\_\_\_

Asthma \_\_\_\_\_ Kidney Disease \_\_\_\_\_

Bronchitis \_\_\_\_\_ Bedwetting >10yrs old \_\_\_\_\_

Wheezing \_\_\_\_\_ Epilepsy, Seizures or Convulsions \_\_\_\_\_

Mental Illness \_\_\_\_\_ Autism \_\_\_\_\_

Heart Disease <50yrs old \_\_\_\_\_ Alcohol Abuse \_\_\_\_\_

Heart Attack <50yrs old \_\_\_\_\_ Drug Abuse \_\_\_\_\_

Blood Pressure <50yrs old \_\_\_\_\_ Genetic Disorders \_\_\_\_\_

Migraines \_\_\_\_\_ Other Immune Problems \_\_\_\_\_  
Diabetes <50yrs old \_\_\_\_\_ Skin Conditions \_\_\_\_\_  
Cancer; list type \_\_\_\_\_

## **Social History**

### **General:**

Parent Information: Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single Parent \_\_\_

Patient lives with \_\_\_\_\_

Pets: Yes\_\_ No\_\_; If so, what type & how many? \_\_\_\_\_

Guns in the household: Yes\_\_ No\_\_; If yes, are the guns locked & separate from ammunition? \_\_\_\_\_