Patient: ____________________

NEWBORN REGISTRATION

Today's Date ____________ Referred By ____________

MR #: ____________ DOB: ____/____/____

FAMILY MEDICAL HISTORY

Check if members of the child's family have had the following illnesses or problems. List appropriate initial after each.

Initial Codes: F = Father M = Mother
S = Sister BR = Brother G = Grandparent

- ❑ Allergies ____________
- ❑ Receives Allergy Shots ____________
- ❑ Drug Allergies ____________
- ❑ Asthma ____________
- ❑ Eczema ____________
- ❑ Frequent Respiratory Infections ____________
- ❑ Placement of Ear Tubes ____________
- ❑ Stomach or Intestinal Problems ____________
- ❑ Diabetes ____________
- ❑ Growth Problems ____________
- ❑ Seizures or Convulsions ____________
- ❑ Cholesterol Problems ____________
- ❑ High Blood Pressure ____________
- ❑ Heart Attack or Stroke before age 55 ____________
- ❑ Cancer ____________
- ❑ Hereditary Problems ____________
- ❑ Emotional or Behavioral Problems ____________
- ❑ Alcohol or Drug Problems ____________
- ❑ HIV or Immune Compromised ____________
- ❑ Other ____________
- ❑ Other ____________

Did mother have any health problems during pregnancy?

____

____

Did mother use tobacco, alcohol or recreational drugs during pregnancy?

❑ No ❑ Yes (List type) ____________

____

____

MATERNAL HISTORY

Mother's Age ________

G ________ Para ________ AB ________ Blood Type ________

Pregnancy: ❑ Normal ❑ Abnormal
❑ Normal ❑ Abnormal

Delivery: ❑ Vaginal ❑ C-Section for: ________

Problems: ____________

____

____

RPR status: ❑ Non-reactive ❑ Reactive

HIV status: ❑ Negative ❑ Positive

Hepatitis B Screen: ❑ Negative ❑ Positive

NEWBORN HISTORY

Sex: ❑ Male ❑ Female

Date of Birth: ________ Date of Discharge: ________

BW: ________ LGTH: ________ HC ________ Apgars: ________

Blood Type: ________ Coombs: ________

Hearing screening: ❑ Normal ❑ Abnormal

Examination: ❑ Normal ❑ Abnormal ________

Problems: ____________

____

____

Feedings: ❑ Breast ❑ Formula

Metabolic Screen: ❑ No ❑ Yes Date: ________

Hepatitis B Vaccine: ❑ No ❑ Yes Date: ________

HBIG: ❑ No ❑ Yes Date: ________

Daily Weights				Disch. Wt.

Date	Hct	Glucose	Direct Bilirubin	Total Bilirubin

____________, M.D. I.D. #: ____________ Date: ____________

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