



<b>Original Date:</b>	
<b>Dates Revised:</b>	12/09/2014

## NEWBORN REGISTRATION QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

<b>Name</b> (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>	<b>SSN:</b>
Mailing Address:		Street:	Apt :	
		City:	State:	Zip:
Home Phone:	Parent Work Phone:	Parent Cell Phone:		
<b>Birth weight:</b>				
<b>Guarantor Information</b> (Responsible Party)				
<b>Name</b> (Last, First, M.I.):		<b>DOB:</b>	<b>SSN:</b>	
<b>OTHER RESPONSIBLE PARTIES</b>				
<b>Name</b> (Last, First, M.I.):		<b>Relationship to patient:</b>		
<b>Name</b> (Last, First, M.I.):		<b>Relationship to patient:</b>		
<b>Name</b> (Last, First, M.I.):		<b>Relationship to patient:</b>		
<b>Name</b> (Last, First, M.I.):		<b>Relationship to patient:</b>		
<b>EMERGENCY CONTACT</b>				
<b>Name</b> (Last, First, M.I.):		<b>Phone:</b>	<b>Relationship to patient:</b>	

### BIRTH/MEDICAL HISTORY

Delivery Hospital:	Date of Discharge:	How many weeks was parent at delivery:
Adopted?	If Yes, at what age?	
Type of Delivery:	Vaginal <input type="checkbox"/>	C-Section <input type="checkbox"/>
If C-Section, explain why?		
Breast fed?	If formula fed, which brand?	
Explain all other pregnancy related problems?		
Did your child pass his/her hearing screen?		
Did your child get his/her newborn metabolic screening drawn?		
Was your child exposed to any tobacco, alcohol, or drugs (prescribed or illicit) during pregnancy?		
<b>Maternal Infection Exposure</b> (check all that apply)	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Group B Strep
	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chlamydia
	<input type="checkbox"/> Herpes	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other
<b>Surgeries</b>		
Year	Reason	Hospital

<b>Other hospitalizations</b>		
Year	Reason	Hospital
<b>Are your immunizations up to date (current)? Please bring records.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

**List the primary pharmacies used over the last two years (24 months): (Use back page if more than two were used)**

<b>Pharmacy 1:</b> name:	Phone number	( )
Street address:	City:	State: ZIP Code:
Dates from:	To:	
<b>Pharmacy 2:</b> name:	Phone number	( )
Street address:	City:	State: ZIP Code:
Dates from:	To:	

**List your prescribed drugs and over-the-counter drugs, such as vitamins, herbs and inhalers**

Name the Drug	Strength	Frequency Taken

**Allergies to medications**

Name the Drug	Reaction Your Child Had

**LEAD AND TB RISK ASSESSMENT**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

<input type="checkbox"/> Child has a history of lead exposure
<input type="checkbox"/> Home built before 1970
<input type="checkbox"/> Home has chipping or peeling paint
<input type="checkbox"/> Parent's occupation involves lead exposure (i.e. battery recycling plant, radiator repair, etc.)

<input type="checkbox"/> Child eats clay, paint chips, etc.		
<input type="checkbox"/> Child has ingested folk remedies (i.e. Azarcon, Greta, Ghasard, Ba-Baw-San)		
<input type="checkbox"/> Child has immediate family members, playmates, or neighbors with a history of lead exposure		
<input type="checkbox"/> Family is currently homeless or living in a shelter		
<input type="checkbox"/> Child has TB, HIV, AIDS		
<input type="checkbox"/> Child immigrated from a country endemic to TB i.e. India, South East Asia, Central or South America, Haiti, Russia, etc.		

SOCIAL HISTORY		
Is your child in daycare?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there any firearms/guns in the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there pets in the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child exposed to any tobacco products at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Who has custody of the child?		
Who lives in the home with the child?		

### FAMILY HEALTH HISTORY

Do any family members have any of the following conditions?

	<i>Mother</i>	<i>Father</i>	<i>Sibling</i>	<i>Maternal Grandfather</i>	<i>Maternal Grandmother</i>	<i>Paternal Grandfather</i>	<i>Paternal Grandmother</i>
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug/alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged QT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Infant Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Other? Please Describe*

**Disclosure:**  
 Please provide the most current and complete information in this history questionnaire. This information is used solely by the physician and staff for the purpose of determining your medical needs and services. The information will assist in assessing if any exceptional or specialized services may be required, and how it can be best delivered to each unique patient and her medical needs.