New Patient (newborn) Profile:

Patient name: _____ Today's date: _____ Age: _____

Mother's name: _____ Father's name: _____

Patient's Past Medical History:

Date of birth: _____ Place of birth: _____

Gestational age at birth: _____ weeks. Type of delivery: ___ Vaginal ___ C-section

If C-section, reason: _____

During your baby's initial hospitalization, were there any complications?	___ Yes ___ No
Did he/she require any special feedings?	___ Yes ___ No
Did he/she require IV fluids or medications?	___ Yes ___ No
Did he/she require any consultations with a specialist?	___ Yes ___ No
Did he/she require any Intensive?	___ Yes ___ No
Was he/she kept in the hospital beyond the routine newborn period?	___ Yes ___ No
Did he/she require readmission to the hospital after being discharged?	___ Yes ___ No
Did he/she require treatment for jaundice?	___ Yes ___ No
Has he/she been seen at any medical facility for any reason since being discharged?	___ Yes ___ No
Is he/she on any medications?	___ Yes ___ No
Does he/she have any known allergies?	___ Yes ___ No
Was he/she diagnosed with any medical condition prior to delivery?	___ Yes ___ No

Please explain any yes answers above: _____

_____

_____

Siblings: Does patient have any siblings? ___ Yes ___ No If yes, give names below.

	Name:	Health status:	Living or deceased?	Cause of death
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Family's past medical history:

Does any family member have any disease that may be hereditary or place this patient at risk? ___ Yes ___ No

Is mother deceased? ___ Yes ___ No

Is father deceased? ---------- ___ Yes ___ No

Does mother use tobacco? ___ Yes ___ No

Is mother in overall good health? ---------- ___ Yes ___ No

Does father use tobacco? ___ Yes ___ No

Is father in overall good health? ---------- ___ Yes ___ No

Did mother require any special care during the hospitalization? ___ Yes ___ No

During this child's delivery, was mother kept in the hospital beyond the routine newborn period? ___ Yes ___ No

Explain any yes answers above: _____

_____

_____

Has any family member of this patient (parent, grandparent, biological sibling, aunt or uncle) ever been diagnosed or treated for any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV	___	___	Frequent cough	___	___	Leukemia	___	___
ADHD	___	___	Frequent diarrhea	___	___	Liver disease	___	___
Anyphylaxis	___	___	Frequent headaches	___	___	Low blood pressure	___	___
Anemia	___	___	Genital herpes	___	___	Lung disease	___	___
Arthritis/Gout	___	___	Glaucoma	___	___	Psychiatric care	___	___
Asthma	___	___	Hay fever	___	___	Radiation treatment	___	___
Blood disease	___	___	Heart failure	___	___	Recent weight loss	___	___
Blood transfusion	___	___	Heart attack	___	___	Rheumatic fever	___	___
Breathing problem	___	___	Heart disease	___	___	Shingles	___	___
Bruising easy	___	___	Hemophilia	___	___	Sickle cell disease	___	___
Cancer	___	___	Hepatitis B	___	___	Sinus problems	___	___
Chemotherapy	___	___	Hepatitis A or C	___	___	Spina bifida	___	___
Chest pain	___	___	Herpes	___	___	Stomach/intestinal dz	___	___
Congenital heart disease	___	___	High blood pressure	___	___	Stroke	___	___
Diabetes	___	___	High cholesterol	___	___	Swelling of limbs	___	___
Drug addiction	___	___	Hives	___	___	Thyroid disease	___	___
Emphysema	___	___	Hypoglycemia	___	___	Tuberculosis	___	___
Epilepsy or seizures	___	___	Irregular heartbeat	___	___	Tumors	___	___
Excessive bleeding	___	___	Jaundice	___	___	Stomach ulcers	___	___
Excessive thirst	___	___	Joint disease	___	___	STD	___	___
Fainting spells/dizziness	___	___	Kidney problems	___	___			

Social History:

Patient lives with: ___ mother ___ father ___ both ___ Other: _____
Primary household language spoken: _____
Is patient exposed to tobacco smoke or excess alcohol consumption in the home? ___ Yes ___ No

Signature of parent/legal guardian completing this form. _____ Date: _____

This form was reviewed on _____ by _____