



NEWBORN REGISTRATION

Today's Date _____ Referred By _____

Patient: _____

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: _____