

## PRENATAL VISIT / FIRST TIME NEWBORN

Baby's name (if applicable) Due / birth date Today's date

Referred by OB / Midwife Hospital of delivery

What is the sex of the baby?  Boy  Girl  Unknown  
 Are you or do you plan to breastfeed?  Yes  No  Don't know  
 Have you had any breast surgeries?  Yes  No  Don't know  
 Did you or do you plan to circumcise?  Yes  No  Don't know

Mother's name Occupation Age

Father's name Occupation Age

Sibling's name Medical problems Age

Sibling's name Medical problems Age

Sibling's name Medical problems Age

Marital status:  Married  Single  Separated  Divorced  Other

Who does / will the child live with after the child is born?

Does anyone in the home smoke cigarettes, drink alcohol or use street drugs?

Does your family observe any special diets?

Any religious / spiritual affiliations?

**OBSTETRIC HISTORY:**

Any previous pregnancies?

Any miscarriages, abortions or stillbirths?

Any complications or concerns during this pregnancy? (infections, diabetes, high blood pressure, other)

Did the babies have any complications at birth?(jaundice, feeding problems)



**MOTHER'S MEDICAL HISTORY:**

Allergies:

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Medications (including vitamins and herbals):

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Medical Problems/Issues:

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**FATHER'S MEDICAL HISTORY:**

Allergies:

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Medications (including vitamins and herbals):

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Medical Problems/Issues:

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**FAMILY HISTORY:**

Has anyone in the family ever had or been treated for the following? (Include the child's siblings, mother, father, grandparents, aunts and uncles.)

Allergies, sinus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food allergy/intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing, asthma, bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Positive PPD/TB	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema or skin problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis or liver problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression / psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drug or alcohol problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Other:

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If the baby is already born, please fill out the following:

Hospital of delivery:

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Vaginal delivery or C-section?

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Birth weight:

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Gestational Age (number of weeks):

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If male, was he circumcised?

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Any complications? (jaundice, low glucose, antibiotics needed)

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