Benton Pediatrics, Inc.

Board Certified Pediatrics
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NEWBORN VISIT

ALL RESPONSES ARE CONFIDENTIAL

Today's Date _____

Any Known Allergies To Medicines? _____

Patient's Full Name _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

Other Children? If Yes, Names And Ages

Name _____ Age _____
Name _____ Age _____
Name _____ Age _____
Name _____ Age _____

Home Phone _____
Work Phone Or Cell Phone? _____
Emergency Contact Number (Someone We Can Call If We Can't Reach You)

_____

Employment Of Parents _____
Does Eitther Parent Stay Home? _____
Does Anyone In The Household Smoke? _____
Are There Pets? _____ What Type? _____
Religion _____
House of Worship Attended_____
Daycare For Other Children? _____
Parents Married? _____
Home Schooling For Any Other Children? _____
Do You Have Well Water Or City Water? _____
Dentist For Other Children? Dentist's Name _____

Date Of Birth (Baby) _____ Birth Weight _____

Birth Length _____ Head Circumference _____

Full Term Or Premature? _____

If Preemie, Number Of Weeks Early _____

Problems With Pregnancy? _____

_____

_____

Delivery Type (Vaginal, C-Section) _____

Vacuum Extraction, Forceps? _____

Complications Of Delivery? _____ OB / Midwife _____

Place Of Birth _____ Length Of Stay _____

Baby's Weight At Discharge From Hospital _____

Blood Transfusion For Baby After Birth? _____

Antibiotics Needed For Baby After Birth? _____

Jaundice? _____ Bilirubin Lights Needed? _____

Oae (Hearing Screen) Passed? _____

Apgar Scores: _____ / _____

Mom Screened For HIV And Hepatitis B? (Negative Or Positive, Circle One)

Smoking During Pregnancy? If Yes, How Much? _____

Any Alcohol Or Drugs (Including Prescription Medications)

Taken During Pregnancy? _____

Any Household Member Or Frequent Visitor To Home Who Has

Tuberculosis, Any Form Of Hepatitis Or Is Hiv Posiitve? _____

If Baby Is A Boy, Is He Circumcised? _____

Feeding Method: Formula, Breast, Both (Circle One)

How well do you think your baby is eating?

Very Well _____ Not Very Well _____

How well do you think your baby is sleeping?

Very Well _____ Not Very Well _____

Child's Name _____

FAMILY HISTORY, including baby's brothers/sisters, mom and dad, grandparents on both sides, true uncles and aunts, and first cousins
(CHECK ALL THAT APPLY):

ADD/ADHD
Allergies
Asperger's
Asthma
Atopic Dermatitis
Autism
Autistic Spectrum Disorder
Bleeding Disorder
Blindness
Cancer
Chron's Disease
Chronic Constipation
Chronic Diarrhea
Chronic Headaches
Chronic kidney infections
Cluster Headaches
Deafness
Depression
Developmental Delay
Diabetes
Eczema
Fibromyalgia
Gallstones
Goiter
Heart Attack
Heart Bypass surgery
Heart Defect
High Blood Pressure
High Cholesterol
HIV or AIDS
Hives
Huntington's Chorea
Hyperthyroidism
Hypogycemia (low sugar)
Hypothyroidism
Irritable Bowel Disease
Kidney Failure
Kidney Stones
Lactose Intolerance
Lazy eye
Learning Disability
Lupus
Manic Depressive Disorder
Migraine Headaches
Multiple Sclerosis
Muscular Dystrophy
Obesity
Obsessive Compulsive Disorder
Oppostional Defiant Disorder
Psoriasis
Rheumatoid Arthritis
Schizophrenia
Scleroderma
Seizures
Severe Mood Swings
Sickle Cell Disease
Stroke
Tourette's
Tuberculosis
Ulcerative Colitis

OTHER (please list any other specific conditions or diseases)

_____

_____

_____

DO YOU HAVE ANY SPECIAL CONCERNS?

_____

_____

_____

Child's Name _____