RAINBOW PEDIATRIC CENTER

Newborn Patient Questionnaire

Date of 1st visit: ____/____/_____ Patient Name: _____ DOB: ____/____/_____

MOTHER

Name: _____
DOB:_____/_____/_____ Age: _____
Address:_____
City: _____State: ____ Zip:_____
Home Phone: _____ Cell: _____
Email: _____
Employer: _____
Occupation: _____Wk phone: _____
Will mom return to work: YES / NO When? _____

FATHER

Name: _____
DOB:_____/_____/_____ Age: _____
Address:_____
City: _____State: ____ Zip:_____
Home Phone: _____ Cell: _____
Email: _____
Employer: _____
Occupation: _____Wk phone: _____

Who does the child reside PRIMARILY with: both parents / mother / father / other: _____

Any court documents documenting custody of this child? YES / NO If yes, please provide copies for our records.

PREGNANCY & BIRTH

Mother's age at birth: _____ Father's Age: _____
Did mom have prenatal care? YES / NO
Did mother have any illness during pregnancy: YES / NO
If so: _____
Did she take any meds other than vitamins: YES / NO
How many weeks gestation was the baby: _____
Baby's birth weight: _____ Single / Multiple
Delivery Method: Vaginal / C-Section / Vacuum / Forceps
Did the baby have any trouble starting to breath: YES / NO
Was the baby admitted to the NICU? YES / NO
Hospital of birth: _____
Date of Discharge: _____ / _____ / _____
Breast feeding: yes / no Formula: _____

FAMILY HISTORY

Are the babies parents in good health: YES / NO
Please circle any diseases this babies parents, grandparents or siblings have had: *asthma, anemia, allergies, diabetes, high blood pressure, heart problems, tuberculosis, mental illness, drug or alcohol problems, inherited illnesses, sexually transmitted diseases, cancer, AIDS, other*: _____

List age, sex, any medical diagnosis of siblings
_____
_____
_____

SAFETY & ENVIROMENT

Do you live in a house / apartment / townhouse / mobile home other: _____
Do you know the hottest temperature of the water in your pipes? YES / NO Temp: _____
Is there a working smoke alarm on each floor of the home? YES / NO
Does your child ALWAYS use a car seat? YES / NO Type of care seat: _____ Age of car seat: _____
Are there any smokers in the household: YES / NO Inside / Outside / Car / Social Only
Does your child have older siblings who live in the home: YES / NO Are there any pets in the home? YES / NO
Where will your baby sleep? Co-sleeping / bassinet / crib / pack n play / other: _____
Will your child be attending daycare? YES / NO What age will they begin: _____

Name of Childcare Provider: _____ Phone: _____