



# Livermore/Pleasanton Pediatrics Group

Infants • Children • Young Adults

## NEWBORN HEALTH QUESTIONNAIRE

Birth date: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Hospital: \_\_\_\_\_ Male  Female

City/State: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Relationship of person filling out form to child: \_\_\_\_\_

### Pregnancy – Birth History – Family History

*(Place a check mark on response.)*

	Yes	No
Did mother have health problems during pregnancy?	_____	_____

Did mother smoke, drink, or take drugs during pregnancy?	_____	_____
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Was baby born on time? (# of weeks early or late _____)	_____	_____
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Was birth:  vaginal  c-section

Were there any problems with the baby at birth?	_____	_____
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If yes, please describe: \_\_\_\_\_

Were there any problems with the baby in the nursery?

If yes, please describe: \_\_\_\_\_

What was the birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

How many other children are in the family \_\_\_\_\_ Which number child is this? \_\_\_\_\_

Who spends the most time with this child  Mother  Father  Grandparent  Childcare Provider

*(fill in below)*

Daytime: \_\_\_\_\_ Evening: \_\_\_\_\_ Overnight: \_\_\_\_\_