

PEDIATRIC ASSOCIATES OF GREATER SALEM

DATE _____

Newborn Health Summary

BABY'S NAME _____ Male Female Home Delivery
 MOTHER'S NAME _____ Occupation: _____ Birthdate _____ Hosp. _____
 FATHER'S NAME _____ Occupation: _____ Obstetrician _____

WEIGHT AT BIRTH		LENGTH		HEAD		DISCHARGE WEIGHT	
Grams	Pounds	Cm	Inch	Cm	Inch	Grams	Pounds

MATERNAL HISTORY

Mother's Age _____ Father's Age _____

Grav.	Para	Ab	Stillbirths	E D C	Bld. Grp.	Rh	Serology	Maternal Serum Alpha-fetoprotein	Rubella / Titer	Hepatitis B Surface Antigen (HBsAg)

MOTHER'S PAST GESTATIONAL HISTORY

Medical Problem (See reverse for problem list): _____

Medications: _____ Tobacco Use: _____

Alcohol Use: _____ Drugs (See reverse for drug list): _____

Maternal Weight Gain _____ Maternal Diet: Regular Diet Vegetarian Other

Vitamins & Mineral Supplements _____

Any Dietary Deficiencies _____

Was Prenatal Ultrasound Performed? Yes No RESULTS: _____

(Additional space over)

LABOR & DELIVERY RECORD

Complications - This pregnancy (see reverse for complication list): _____

Membranes ruptured: _____ Hours Character amniotic fluid: Clear Meconium

Labor: _____ Hours Spontaneous Induced

Presentation: Vertex Breech

Delivery: Spontaneous Precipitous Forceps Vacuum C-Section Other

Anesthesia/Analgesia: _____

CONDITION OF INFANT AT BIRTH

Breathed: Spontaneously _____ Min. after birth Suction With stimulation _____ Min. after birth Oxygen by mask

Apgar Score _____ 1 Min. _____ 5 Min. Assisted Ventilation _____ Intubation _____

Number of Umbilical Cord Vessels _____

DIAGNOSIS: TERM BIRTH LIVING CHILD PREMATURE BIRTH LIVING CHILD

Major Defects or Handicaps

Minor Defects

(1) _____ (4) _____ (1) _____

(2) _____ (5) _____ (2) _____

(3) _____ (6) _____ (3) _____

NEWBORN SCREENING RESULTS:

Phenylketonuria: _____ Pos. Neg. Galactosemia Pos. Neg.

Congenital Primary Hypothyroidism Pos. Neg. Sickle Cell Disease / Trait Cystic Fibrosis Maple Syrup Urine Disease

Homocystinuria Biotinidase Deficiency Congenital Adrenal Hyperplasia Toxoplasmosis Thalassemias Other _____

FEEDING Breast Formula _____

FAMILY MEDICAL HISTORY Please write in the relationship of the mother's or father's relatives (such as children, brothers, sisters, grandparents, aunts, uncles) who have had any of the conditions listed. Include conditions that baby's mother and father have had.

(x)	CONDITION	RELATIONSHIP	MAT (✓)	PAT (✓)
	Birth Defects			
	Chromosomal Abnormality (Genetic Disease)			
	Obesity / Overweight			
	DES Exposure			
	Congenital Hearing Loss			
	Mental Retardation / Nervous Disorders			
	Migraine Headaches			
	Food Allergies			
	Hay Fever			
	Asthma / Emphysema			
	High Blood Pressure			
	Heart / Valve Trouble			
	Coronary Artery Disease (Note age at death)			
	Stroke			
	Rheumatoid Arthritis / Gout			
	Rheumatic Fever			
	Cancer or Malignancy			

(x)	CONDITION	RELATIONSHIP	MAT (✓)	PAT (✓)
	Metabolic Disease / Thyroid Problem			
	Alcoholism			
	Diabetes			
	Muscular Dystrophy			
	Eye Disease / Glaucoma			
	Cystic Fibrosis / Lung Disease			
	Tuberculosis			
	Anemia / Blood Disorders			
	Bleeders / Hemophilia			
	Convulsive Disease (Epilepsy)			
	Hepatitis / Gall Bladder Disease			
	Peptic Ulcer / Colitis / Irritable Bowel			
	Venereal Disease			
	Kidney Problems (1) Infections			
	(2) Malformations			
	AIDS / ARC / HIV POSITIVE			

THE SECTIONS BELOW APPLY ONLY TO THE MOTHER.
PLEASE ANSWER BY CHECKING YES OR NO IN APPROPRIATE BOXES.
LIST ALL POSITIVE RESPONSES IN APPROPRIATE SPACES ON THE FRONT OF THIS PAGE.

<u>COMPLICATIONS THIS PREGNANCY</u>			<u>MEDICAL PROBLEMS OF MOTHER</u>		
<u>CONDITION</u>	<u>NO</u>	<u>YES</u>	<u>CONDITION</u>	<u>NO</u>	<u>YES</u>
MULTIPLE BIRTHS 2 - 3 - 4 - 5	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
PREVIOUS C-SECTION 1 - 2 - 3	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
BREECH PRESENTATION	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS / CYSTIC FIBROSIS	<input type="checkbox"/>	<input type="checkbox"/>
<u>INFECTIONS</u>			EPILEPSY SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
RUBELLA (3 DAY MEASLES)	<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
GENITAL HERPES	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
VENEREAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA / BLOOD DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
IF YES - NAME _____			CANCER / MALIGNANCY	<input type="checkbox"/>	<input type="checkbox"/>
URINARY TRACT INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	POSITIVE AIDS TEST	<input type="checkbox"/>	<input type="checkbox"/>
VIRUS TYPE ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____		
IF YES - NAME _____			_____		
FEVER OF UNKNOWN ORIGIN	<input type="checkbox"/>	<input type="checkbox"/>	_____		
SAUNA / HOT TUB USE	<input type="checkbox"/>	<input type="checkbox"/>	<u>ULTRASOUND TESTS</u>		
PRE-ECLAMPSIA	<input type="checkbox"/>	<input type="checkbox"/>	WERE PRENATAL ULTRASOUND TESTS DONE	<input type="checkbox"/>	<input type="checkbox"/>
<u>ECLAMPSIA</u>			IF YES - STATE RESULTS		
PROTEIN IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	_____		
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____		
EDEMA	<input type="checkbox"/>	<input type="checkbox"/>	_____		
PREMATURE SEPARATION OF PLACENTA			_____		
PLACENTA PRAEVIA	<input type="checkbox"/>	<input type="checkbox"/>	_____		
SECOND OR THIRD TRIMESTER BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	_____		
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
_____			_____		

<u>CONTROLLED SUBSTANCES AND DRUGS</u>					
FOR ALL YES ANSWERS DESCRIBE FREQUENCY AND QUANTITIES OF USE AND WEEK(S) OF PREGNANCY WHEN USED.					
<u>NARCOTICS</u>			<u>HALLUCINOGENS</u>		
MORPHINE	<input type="checkbox"/>	<input type="checkbox"/>	MARIJUANA	<input type="checkbox"/>	<input type="checkbox"/>
HEROIN	<input type="checkbox"/>	<input type="checkbox"/>	HASHISH	<input type="checkbox"/>	<input type="checkbox"/>
METHADONE	<input type="checkbox"/>	<input type="checkbox"/>	MESCALINE	<input type="checkbox"/>	<input type="checkbox"/>
CODEINE	<input type="checkbox"/>	<input type="checkbox"/>	LSD	<input type="checkbox"/>	<input type="checkbox"/>
PERCODAN	<input type="checkbox"/>	<input type="checkbox"/>	PCP (ANGEL DUST)	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
<u>STIMULANTS</u>			<u>TRANQUILIZERS & ANTIDEPRESSANTS</u>		
AMPHETAMINES	<input type="checkbox"/>	<input type="checkbox"/>	LIBRIUM	<input type="checkbox"/>	<input type="checkbox"/>
METHAMPHETAMINES	<input type="checkbox"/>	<input type="checkbox"/>	VALIUM	<input type="checkbox"/>	<input type="checkbox"/>
DIET PILLS	<input type="checkbox"/>	<input type="checkbox"/>	ELAVIL	<input type="checkbox"/>	<input type="checkbox"/>
COCAINE ("CRACK")	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
<u>SEDATIVES</u>			_____		
BARBITURATES	<input type="checkbox"/>	<input type="checkbox"/>	_____		
QUAALUDES	<input type="checkbox"/>	<input type="checkbox"/>	_____		
SECONAL	<input type="checkbox"/>	<input type="checkbox"/>	_____		
DORIDEN	<input type="checkbox"/>	<input type="checkbox"/>	_____		
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		