

MEDICAL AND SOCIAL HISTORY FORM

This form is intended to provide you an opportunity to anonymously provide information about your newborn and his/her family medical history. This information can be very helpful for your child's future medical care.

TRANSFER INFORMATION				
Date Newborn Transferred:		Hospital / Fire Station:		ID Band Number:
DELIVERY INFORMATION				
Date and time of birth		Date:		Time:
Place of birth	<input type="checkbox"/> Hospital	<input type="checkbox"/> Home	Other:	
Delivered by (If not hospital delivery)	<input type="checkbox"/> Midwife	<input type="checkbox"/> Mother	<input type="checkbox"/> Father/family/friend	
Position at birth	<input type="checkbox"/> Head first	<input type="checkbox"/> Bottom first	Other:	
Cried at birth	<input type="checkbox"/> Right away	<input type="checkbox"/> Delayed, but soon	Other:	
Baby moving arms/legs at birth?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Baby's coloring at birth	<input type="checkbox"/> Pink around mouth and pink hands and feet	<input type="checkbox"/> Pink around mouth, bluish hands and feet	<input type="checkbox"/> Bluish around mouth	<input type="checkbox"/> Other:
Placenta (afterbirth) delivered within 10-15 minutes after baby?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
LABOR INFORMATION				
Date/time mother's water broke		Date:		Time:
What color was the fluid?	<input type="checkbox"/> Clear	<input type="checkbox"/> Greenish or brownish	<input type="checkbox"/> Other	
Any odor to the fluid?	<input type="checkbox"/> Yes (describe)		<input type="checkbox"/> No	
Date/time contractions (labor pains) started		Date:		Time:
PREGNANCY INFORMATION				
How far along was the pregnancy?	In Months			
Mother's age	<input type="checkbox"/> Under 17 years old	<input type="checkbox"/> 17-35 years old	<input type="checkbox"/> Over 35 years old	
Prenatal care?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Other pregnancies?	# of pregnancies: Born alive: _____ Premature births (more than 3 weeks early): _____		Low birth weight (under 5½ lbs): _____ Stillborn: _____ Miscarried/abortions: _____	
Complications of this pregnancy? (Bleeding before labor, high blood pressure, high weight gain, infections, morning sickness more than 3 months, etc.)	Describe:			
Complications of past pregnancies?	Describe:			
Substance use during pregnancy	<input type="checkbox"/> Alcohol: _____ Drinks/day for _____ Months of pregnancy	<input type="checkbox"/> Tobacco: _____ Packs/day for _____ Months of pregnancy	<input type="checkbox"/> Prescription drugs: Names: _____	<input type="checkbox"/> Other drugs (street drugs) Names: _____

Descriptions and Characteristics of Birth Family

	Mother	Father	Sibling of Newborn	Other – Identify Relationship
Height				
Weight				
Age <i>(at time of newborn's birth)</i>				
Build/Bone Structure				
Complexion color <i>(fair, medium, dark, olive, light brown)</i>				
Hair color				
Hair texture				
Eye color				
Right or Left handed				
Blood type				
Education <i>(to date)</i>				
Glasses worn? If yes, what for what condition?				
Acne? Age at onset? Treatment?				
Distinguishing characteristics <i>(e.g., birthmarks, scars, tattoos)</i>				
Occupation				
Talents / hobbies / skills				
Family Religion				
Addictions <i>(Drug, Alcohol, Tobacco, etc.)</i>				
Deceased <ul style="list-style-type: none"> • Age • Cause of Death 				

