

Tamalpais Pediatrics New Baby Questionnaire
(Ages up to 1 year)

Name: _____ Birth Date: _____ Today's Date: _____

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| 1. Is your baby adopted? | Yes | No |
| 2. Did you have any problems with previous pregnancies? | Yes | No |
| 3. Did you have any problems with this pregnancy? | Yes | No |
| 4. Were any medications or drugs other than prenatal vitamins or "water pills" taken during your pregnancy? | Yes | No |
| 5. Was your child born more than three weeks before or after your due date? | Yes | No |
| 6. Was your child's delivery complicated by bleeding, unusual position or C-section? | Yes | No |
| 7. a) Was there anything unusual about your labor? | Yes | No |
| b) How long was your labor? _____ | | |
| 8. Was it necessary to use an special means to help your baby breathe? | Yes | No |
| 9. Was your baby blue or unusually yellow during or shortly after his hospital stay? | Yes | No |
| 10. Did your baby remain in the hospital after you left? | Yes | No |
| 11. a) How many pregnancies have you had? _____ | | |
| b) How many children do you have? _____ | | |
| 12. a) What was your baby's birth weight? _____ | XXXXXXXXXX | |
| XXXXXXXXXX b) Where was your baby born? _____ | | |
| 13. Have there been any unusual problems or illnesses? | Yes | No |
| 14. Has your child ever been hospitalized for illness or accident? | Yes | No |
| 15. Have there been any fractures or concussions not resulting in a hospital stay? | Yes | No |
| 16. Have there been any operations? | Yes | No |
| 17. Do feeding problems exist? | Yes | No |
| 18. Do you have questions about your child's diet? | Yes | No |
| 19. Does your child have allergy to food or drug? | Yes | No |
| 20. Was your baby breast fed? _____ How long? _____ | | |

21. What formula was used? _____

22. What formula or milk is now used? _____

23. Is constipation or diarrhea a frequent problem? Yes No

24. Has your child had (check): Measles? Chicken Pox? Rubella?

25. Has any specific chronic illness been diagnosed? Yes No

26. Is there any history of unusual bleeding in this child or his family? Yes No

27. Do you feel there is trouble with your child's eyes? Yes No

28. Do you feel there is trouble with your child's ears? Yes No

29. Do you feel there is trouble with your child's heart? Yes No

30. Do you feel there is trouble with your child's nose and/or lungs? Yes No

31. Do you feel there is trouble with your child's digestive system? Yes No

32. Do you feel there is trouble with your child's skin? Yes No

33. Do you feel there is trouble with your child's bones? Joints? Muscles? Yes No

34. Do you feel there is trouble with your child's bowel movements? Yes No

35. Do you feel there is trouble with your child's legs or feet? Yes No

36. Do you feel there is trouble with your child's urination? Yes No

37. Do you feel there is trouble with your child's strength and/or coordination? Yes No

38. Have frequent earaches been a problem? Yes No

39. Does your child have asthma? Yes No

40. Has anyone ever reported that your child has a heart murmur? Yes No

41. Do you give (check): Vitamins or Fluoride to your baby?

42. Is any other medication given daily? Yes No

43. Check any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, sisters, or first cousins have had:

Tuberculosis Diabetes Asthma Allergy

Convulsions Cancer Ulcers Colitis

Mental Illness Mental Retardation Unusual Inherited Diseases

Diseases of the blood

Glandular Diseases

Heart Disease

Bleeding Disorders

Diseases involving muscles, bones joints

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| 44. | Have there been any deaths in infancy in your families? | Yes | No |
| 45. | Does either parent have medical or serious emotional problems? | Yes | No |
| 46. | Has any member of your immediate family had psychiatric care? | Yes | No |
| 47. | Have you or your spouse been previously married? | Yes | No |
| 48. | Is there unusual tension in the family at the present time? | Yes | No |
| 49. | Are there any medical or emotional problems which have not been mentioned? | Yes | No |
| 50. | Is there any particular problem that you would like to discuss with the doctor? | Yes | No |