



Benton Pediatrics, Inc.

Board Certified Pediatrics

5612 N.W. 43rd Street • Gainesville, FL 32653-3332 • (352) 376-4542

Modified 9/3/03

NEWBORN VISIT

ALL RESPONSES ARE CONFIDENTIAL

Today's Date _____

Any Known Allergies To Medicines? _____

Patient's Full Name _____

Mother's Name _____ Age _____

Father's Name _____ Age _____

Other Children? If Yes, Names And Ages

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Home Phone _____

Work Phone Or Cell Phone? _____

Emergency Contact Number (Someone We Can Call If We Can't Reach You)

Employment Of Parents _____

Does Either Parent Stay Home? _____

Does Anyone In The Household Smoke? _____

Are There Pets? _____ What Type? _____

Religion _____

House of Worship Attended _____

Daycare For Other Children? _____

Parents Married? _____

Home Schooling For Any Other Children? _____

Do You Have Well Water Or City Water? _____

Dentist For Other Children? Dentist's Name _____

Date Of Birth (Baby) _____ Birth Weight _____

Birth Length _____ Head Circumference _____

Full Term Or Premature? _____

If Premie, Number Of Weeks Early _____

Problems With Pregnancy? _____

Delivery Type (Vaginal, C-Section) _____

Vacuum Extraction, Forceps? _____

Complications Of Delivery? _____ OB / Midwife _____

Place Of Birth _____ Length Of Stay _____

Baby's Weight At Discharge From Hospital _____

Blood Transfusion For Baby After Birth? _____

Antibiotics Needed For Baby After Birth? _____

Jaundice? _____ Bilirubin Lights Needed? _____

Oae (Hearing Screen) Passed? _____

Apgar Scores: _____ / _____

Mom Screened For HIV And Hepatitis B? (Negative Or Positive, Circle One)

Smoking During Pregnancy? If Yes, How Much? _____

Any Alcohol Or Drugs (Including Prescription Medications)

 Taken During Pregnancy? _____

Any Household Member Or Frequent Visitor To Home Who Has

 Tuberculosis, Any Form Of Hepatitis Or Is Hiv Posiitve? _____

If Baby Is A Boy, Is He Circumcised? _____

Feeding Method: Formula, Breast, Both (Circle One)

How well do you think your baby is eating?

 Very Well _____ Not Very Well _____

How well do you think your baby is sleeping?

 Very Well _____ Not Very Well _____

Child's Name _____

FAMILY HISTORY, including baby's brothers/sisters, mom and dad, grandparents on both sides, true uncles and aunts, and first cousins
(CHECK ALL THAT APPLY):

- | | | |
|----------------------------|----------------------------|-------------------------------|
| ADD/ADHD | Fibromyalgia | Lupus |
| Allergies | Gallstones | Manic Depressive Disorder |
| Asperger's | Goiter | Migraine Headaches |
| Asthma | Heart Attack | Multiple Sclerosis |
| Atopic Dermatitis | Heart Bypass surgery | Muscular Dystrophy |
| Autism | Heart Defect | Obesity |
| Autistic Spectrum Disorder | High Blood Pressure | Obsessive Compulsive Disorder |
| Bleeding Disorder | High Cholesterol | Oppositional Defiant Disorder |
| Blindness | HIV or AIDS | Psoriasis |
| Cancer | Hives | Rheumatoid Arthritis |
| Chron's Disease | Huntington's Chorea | Schizophrenia |
| Chronic Constipation | Hyperthyroidism | Scleroderma |
| Chronic Diarrhea | Hypogycemia
(low sugar) | Seizures |
| Chronic Headaches | Hypothyroidism | Severe Mood Swings |
| Chronic kidney infections | Irritable Bowel Disease | Sickle Cell Disease |
| Cluster Headaches | Kidney Failure | Stroke |
| Deafness | Kidney Stones | Tourette's |
| Depression | Lactose Intolerance | Tuberculosis |
| Developmental Delay | Lazy eye | Ulcerative Colitis |
| Diabetes | Learning Disability | |
| Eczema | | |

OTHER (please list any other specific conditions or diseases)

DO YOU HAVE ANY SPECIAL CONCERNS?

Child's Name _____