EXPECTED NEWBORN INFORMATION PACKET
PLEASE COMPLETE AND RETURN

Doctor requested: ☐ Kirsten P Magowan MD ☐ Cynthia A Steinem MD

Mother's Name: _____

Baby's Due Date____/_____/_____Obstetrician_____Hospital_____

Baby's Expected Insurance Plan _____ Subscriber _____

****MOTHER'S INFORMATION**

FIRST NAME_____ LAST NAME_____MI _____DOB _____

SS # _____-_____-_____ DRIVER'S LICENSE_____

ADDRESS_

CITY _____STATE _____ZIPCODE _____

Home Phone _____ Work Phone _____Cell Phone _____

Employer_____Email_____

Mother's Insurance Plan_____ID#_____

FATHER'S INFORMATION

FIRST NAME_____ LAST NAME_____MI _____DOB _____

SS # _____-_____-_____ DRIVER'S LICENSE_____

ADDRESS_

CITY _____STATE _____ZIPCODE _____

Home Phone _____ Work Phone _____Cell Phone _____

Employer_____Email_____

Father's Insurance Plan_____ID#_____

The following is very important to your child's health, please complete it as best you can

MOTHERS PRENATAL HISTORY	No	Yes	If Yes - explain
Was this an assisted conception (had to have help getting pregnant)?			
Was this a High Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
Did you have little or late prenatal care?			
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before born?			
Other Issues:			

Is there anything else regarding your baby's health that you think we should know that has not been asked?

_____

_____

_____

Please fill out other side also

Mother's Name: _____ Baby's Due Date_____/_____/_____

You may list details here by family member

Examples of family members:

Maternal (Mother's side):	**Maternal Uncle**	**Paternal (Father's side):**
Mother	**Maternal Aunt**	**Father**
Maternal Grandmother	**Maternal Cousin**	**Paternal Grandmother**
Maternal Grandfather	**Maternal Great-Grandmother**	**Etc.**

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

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Family Member:_____

Diseases/Conditions_____

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Family Member:_____

Diseases/Conditions_____

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Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Family Member:_____

Diseases/Conditions_____

_____

Mother's Name: _____ Baby's Due Date_____/_____/_____

FAMILY MEDICAL HISTORY ***Have any family members had the following:***	**No**	**Yes**	**If Yes – explain, you may put details on next page**
Nasal allergies or other allergies			
Asthma / lung disease			
Heart disease or heart condition			
High blood pressure			
High cholesterol			
Diabetes or other endocrine problem			
Cancer			
Anemia			
Bleeding disorders			
Epilepsy or convulsions			
Mental retardation or developmental disorders			
Neurological disorder including ADHD/ADD			
Liver disease			
Other GI disease / disorder			
Kidney disease			
Bed-wetting (after age 10)			
Hearing impairment			
Vision impairment or eye disorder			
Immune problems, recurrent infections or HIV/AIDS			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Tuberculosis			
Other issues:			
SOCIAL HISTORY	**No**	**Yes**	**Comments**
Lives with both mother and father in same house			
If no, - Lives with:		Relation:	
Visitation status of non-custodial parent (if any)			
Are there Siblings?			
Are there pets in the home?			
Are there guns in the home?			
If yes, are guns locked and kept separate from ammunition?			
Are there any smokers in the home?			
Do you have well water?			
Other issues:			

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature _____Relationship to patient _____

Print Name: _____Today's Date: _____