Victoria Pediatrics and Adolescent Assoc.
Dr. Felix F. Regueira

Name:____ Date Of Birth ______/______/_______

Newborn/New Patient History Form

Birth History:

1. Was your baby full term? Yes No Birth weight _____________Length_________
   If not, how many weeks premature? ________
2. Did you have a vaginal or cesarean delivery? __________
   If cesarean, please explain why. _________________________________
3. Please describe any problems your baby had right after birth.
   ____
4. Did mom have any problems during pregnancy? If yes please describe. Yes No
   ____
5. Was your child exposed to tobacco, alcohol or drugs during pregnancy? Yes No
   If yes, describe, ____
6. Did your baby pass the HEARING screen in the hospital? Yes No
7. Was your baby born BREECH (not head first)? Yes No
8. Place of birth____

New Patients:

Previous Doctor(s)/Pediatrician(s)____

Surgeries (Please explain) Yes No ____

Hospitalizations (Please explain) Yes No ____

Family History:
Please circle Yes/No if any family members have the following and specify relationship:

High cholesterol	Yes	No	________________________________
Heart Disease	Yes	No	________________________________
High Blood Pressure	Yes	No	________________________________
Sudden unexplained death	Yes	No	________________________________
Allergies	Yes	No	What type__________________________
			________________________________
Anemia or Blood Disorder	Yes	No	________________________________
Cancer	Yes	No	What type__________________________
			________________________________
Deafness	Yes	No	________________________________
Diabetes	Yes	No	________________________________
Thyroid disease	Yes	No	________________________________
Recurrent ear infections/Ear tubes	Yes	No	________________________________
Celiac or GI disease/Reflux	Yes	No	________________________________
Mental Illness/Depression	Yes	No	________________________________
Tuberculosis	Yes	No	________________________________
Seizures/Epilepsy/Migraines	Yes	No	________________________________
Mental Retardation/Autism	Yes	No	________________________________
HIV/AIDS	Yes	No	________________________________
Drugs/Alcohol Abuse	Yes	No	________________________________
Asthma or Wheezing	Yes	No	________________________________
Liver or Kidney Disease	Yes	No	________________________________
Learning Disorders	Yes	No	What kind? _________________________

Social History:
Who lives in your home? ____
Does anyone who cares for your baby smoke? ____
Are there pets in the home? Yes No ____
If there are guns in the home, are they locked and secured? Yes No