PEDIATRIC GEMS, PC
EDMOND SARRAF, MD
955 S. Carrillo Dr Ste 210
Los Angeles CA 90048
1-310-888-7778
www.pediatricgems.com

NEWBORN QUESTIONAIRE

INITIAL HISTORY QUESTIONNAIRE

Name of Patient: _____ D.O.B. _____ M___ F ___
Name of Mother:_____ Father:_____
Date Completed: _____

Medications: include all prescription, nonprescription, maintenance & as needed meds
Name _____ Dose _____ How often ?_____
Allergies: _____
Immunizations: Was Hepatitis B given in Hospital? ___yes ___no
Hearing Test: ___Pass ____Failed

Birth History:

Born where _____Gestational Age (weeks)_____
Type of Delivery_____ emergency? _____ Forceps or Vacuum? yes _____ no _____
Birth Weight _____Length _____Head Circumference_____
Feeding, breast or bottle? _____
Group B Strep Positive or Negative (Circle One) Antibiotics Given?_____

Mother's Pregnancy Health:
AbnormalLabs/Tests?_____
(Yes/No) High Blood Pressure ____ Diabetes ____ If so, did this condition exist prior to pregnancy ____
Smoked ____ Drank Alcohol ____ Drugs ____
Birth Complications _____
Problems during the hospital course_____

History of Surgeries at Birth: No ____ Yes _____ If yes, please give details.
Date _____ Surgeon _____ Location _____
Procedure Performed _____

Family Medical History indicate who in relationship to child has the following problems…
Unremarkable (Please select this if all answers below are no) ____
Gastrointestinal Problems _____High Cholesterol _____
Deafness _____ Anemia _____
Nasal Allergies _____ Liver Disease _____
Asthma _____ Kidney Disease _____
Bronchitis _____ Bedwetting >10yrs old _____
Wheezing _____ Epilepsy, Seizures or Convulsions _____
Mental Illness_____Autism_____
Heart Disease <50yrs old _____ Alcohol Abuse _____
Heart Attack <50yrs old _____ Drug Abuse _____
Blood Pressure <50yrs old _____ Genetic Disorders_____

Migraines _____ Other Immune Problems _____
Diabetes <50yrs old _____ Skin Conditions _____
Cancer; list type _____

Social History

General:
Parent Information: Married ___ Separated ___ Divorced ___ Single Parent ___
Patient lives with _____
Pets: Yes__ No__; If so, what type & how many? _____
Guns in the household: Yes__ No__; If yes, are the guns locked & separate from ammunition? ___
Smoking: Yes__ No__; If so, where? _____
Alcohol Use: No ___ Yes ___
Drug Use: No ___ Yes ___