Plattsburgh Primary Care Pediatrics
www.plattsburghpediatrician.com
159 Margaret Street, Suite 103
Ph: (518) 562-0151
Plattsburgh, NY 12901
Fax: (518) 562-2718

New Born Health Questionnaire:

Date: _____ E-mail: (for medical purposes ONLY)_____

Name: _____Date of Birth: _____

Birth Weight:_____pounds Birth Length:_____inches

	Name	Birth Date	Occupation	Healthy?
Father				Y/N
Mother				Y/N
Siblings:				Y/N
				Y/N
				Y/N
				Y/N
Others living in household:				Y/N
				Y/N
				Y/N

Are biological parents living together? Y / N

Please circle response:

Pregnancy was	Normal	Difficult
Delivery was	Normal	Difficult
Baby was full-term	Yes	No
Did the baby have any problems in the Nursery	Yes	No

Please list allergies to food:_____

Please list allergies to medications:_____

Please list any concerns you may have:_____
_____

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Family History: (check all of the following that apply to relatives: Parents, Siblings, Grandparents, Aunts, Uncles, Cousins etc.)

Eczema	Seizure Disorder	Tuberculosis	Hay fever
Diabetes	Asthma	Obesity	High Blood Pressure
Heart attack or Stroke (under age 55)	Anemia or blood problems	High Cholesterol	Death before age 50 (that wasn't due to an accident)
Kidney Disease	Cystic Fibrosis	Cancer	Alcoholism
Mental Retardation	Birth Defects	Psychiatric Problems	
Other:	Other:	Other:	Other: