REIS PEDIATRICS

KAILUA PROFESSIONAL CENTER I | 30 AULIKE ST, SUITE 500, KAILUA, HI 96734 | 808.263.8822

WWW.REISPEDIATRICS.COM

PRENATAL VISIT / FIRST TIME NEWBORN (UP TO 2 MONTHS OLD)

Baby's name (if applicable) | Due / birth date | Today's date

Referred by | OB / Midwife | Hospital of delivery

What is the sex of the baby? ☐ Boy ☐ Girl ☐ Unknown
Are you or do you plan to breastfeed? ☐ Yes ☐ No ☐ Don't know
Have you had any breast surgeries? ☐ Yes ☐ No ☐ Don't know
Did you or do you plan to circumcise? ☐ Yes ☐ No ☐ Don't know

Mother's name | Occupation | Age

Father's name | Occupation | Age

Sibling's name | Medical problems | Age

Sibling's name | Medical problems | Age

Sibling's name | Medical problems | Age

Marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Other

Who does / will the child live with after the child is born?

Does anyone in the home smoke cigarettes, drink alcohol or use street drugs?

Does your family observe any special diets?

Religious / spiritual affiliations?

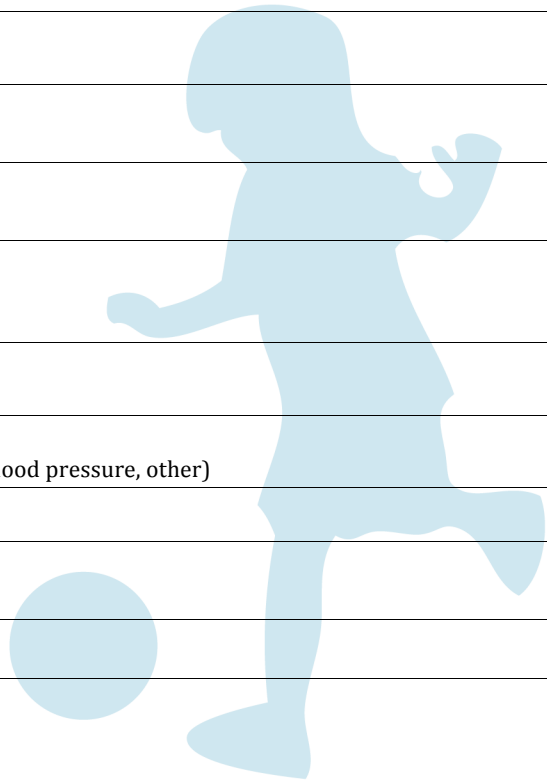
OBSTETRIC HISTORY:

Any previous pregnancies?

Any miscarriages, abortions or stillbirths?

Any complications or concerns during this pregnancy? (infections, diabetes, high blood pressure, other)

Did the babies have any complications at birth?(jaundice, feeding problems)



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MOTHER'S MEDICAL HISTORY:

Allergies:

Medications (including vitamins and herbals):

Medical Problems/Issues:

FATHER'S MEDICAL HISTORY:

Allergies:

Medications (including vitamins and herbals):

Medical Problems/Issues:

FAMILY HISTORY:

Has anyone in the family ever had or been treated for the following? (Include the child's siblings, mother, father, grandparents, aunts and uncles.)

Allergies	☐ Yes ☐ No	Food allergy/intolerance	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Wheezing, asthma, bronchitis	☐ Yes ☐ No
Positive PPD/TB	☐ Yes ☐ No	Eczema or skin problems	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Hepatitis or liver problems	☐ Yes ☐ No
Bowel problems	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Depression / psychiatric	☐ Yes ☐ No	Drug or alcohol problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cancer	☐ Yes ☐ No		

Other:

If the baby is already born, please fill out the following:

Hospital of delivery: Vaginal delivery or C-section?

Birth weight: Gestational Age (number of weeks):

If male, was he circumcised?

Any complications? (jaundice, low glucose, antibiotics needed)