

NEW BABY FORM

Patient Name:																							
Last				_ First							_ MI					Nickname							
DOB/					Place of birth																		
Birth Weight				Discharge Weight								Birth Length											
Gestational age	at d	leliv	ery_																				
Delivery method	l: 🗀] va	gina	al [] c	-sec	tion	١															
Number of Previ	ous	Pre	gna	ncie	es			Deli	iveri	es_			_										
Pregnancy Com	olica	atior	าร																				
Delivery Compli																							
Breech: yes																							
Concerns in Nev			urse	erv																			
Passed Hearing																							
During this preg				•																			
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Please List:												•			,			S			,		
Feeding History		_		_	_																		
Previous history								. Г	7 ve	ا ءد	٦n	0											
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FAMILY HISTOR	(Y																						
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		و ف								e,		Mental Retardation	Rashes/ Skin Problems		emia		0.				Learning Disabilities		
	Abuse	sevel				,,	nse	tack	nsion)iseas	llness	Retarc	Skin		II An	Loss	olestr	sease	osis	DD	Disa	355	fects
	Alcohol Abuse	Allergy - severe	Anemia	Asthma	Cancer	Diabetes	Drug Abuse	Heart Attack	Hypertension	Kidney Disease	Mental Illness	ntal	shes/	Seizures	Sickle Cell Anemia	Hearing Loss	High Cholestrol	Heart Disease	Tuberculosis	ADHD/ADD	rning	Vision Loss	Birth Defects
Relationship	Alc	Alle	Ane	Ast	- Ea	Dia	Dru	He	Ŧ	Kid	Me	Me	Ras	Sei	Sic	He	Ξ̈́	He	ž	AD	Fea	Vis	Bir
Mother																							
Father																							
Sister																							
Brother Maternal Aunt																							
Maternal Uncle																							
Paternal Aunt																							
Paternal Uncle																							
Maternal Grandma																							
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