Dorin Kemmerle, MD LLC dba Sprout Pediatrics
4350 Commercial St SE, Salem, OR 97302
(503) 877-4485 (888) 977-1263
SproutPediatrics.com

Health History (Newborn)

Child's Name: _____ Birthdate: _____
Nickname: _____ Sex: M / F

Birth history: Birth weight: _____ Length: _____
Place of birth: _____ Obstetrician: _____
How long did the baby stay in the hospital after birth? _____
Vaginal birth? Y / N If not, why? _____
Was your child born at term? Y / N If less than 38 weeks, why? _____
_____ Gestational age: _____ weeks
Any problems after birth? Y / N _____
_____
Any problems during pregnancy? Y / N _____
_____
Testing & results during or prior to pregnancy: Hepatitis B: + / - Group B strep: + / -
Others? _____
Smoking, alcohol, drugs, or medications in pregnancy? Y / N _____
How many pregnancies have you had? _____ How many living children do you have? _____
Did your baby get: Erythromycin eye ointment? Y / N Vitamin K shot? Y / N Hepatitis B shot? Y / N
First newborn screen (heel stick before going home)? Y / N
Did your baby pass his/her: Hearing screen? Y / N Heart/oxygen screen? Y / N
Were you told your child had high bilirubin or jaundice? Y / N Do you know the level? _____
Did your baby have blood sugar checks? Y / N Did you get antibiotics in labor? Y / N Rhogam? Y / N

Social & Safety

With whom does your child live? _____
Religious/spiritual affiliation? _____ Pets?_____
Are there firearms in your house? Y / N How are they stored? _____
Does anyone at home smoke? Inside? Y / N Outside? Y / N In the car? Y / N
Does anyone else smoke around your child? Y / N _____
What are your plans for feeding your baby? _____
_____
Where will your baby sleep? _____
Who do you have available to help? _____
How long are your maternity/paternity leaves? _____
What are your plans for work & childcare? _____
_____
Are you comfortable with your child safety seat's installation and use? Y / N
Have you thought about baby proofing? Y / N
Have you both had flu shots and Tdap boosters this year? Mom Y / N Dad Y / N
Have you discussed these immunizations with the baby's close contacts? Y / N

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Family History:

Baby's genetic mother: _____ Baby's genetic father: _____

If any family members have had the following conditions, please list whom:

Allergies: _____
Breathing problem: _____
Obesity: _____
Diabetes: _____
High blood pressure: _____
High cholesterol: _____
Heart disease before age 50: _____
Stroke: _____
Blood problem: _____
Anemia: _____
Liver problem: _____
Gastrointestinal problems: _____
Bed wetting after 5 years old: _____
Kidney problem: _____
Hearing problem: _____
Vision or eye problems: _____
Skin problem: _____

Developmental problem: _____
Learning problem: _____
Neurologic problem: _____
Headaches: _____
Depression/Suicide: _____
Other mental illness: _____
Alcohol abuse: _____
Drug use: _____
Autoimmune disease: _____
Thyroid problems: _____
Genetic disorder: _____
Cancer: _____
Significant infection: _____
Accidental/unexplained death: _____
Other: _____
_____

Pharmacy preferences:

Local: _____
Mail Order: _____

Anything else you want me to know?

_____ _____
Parent signature Today's date