NEWBORN/INFANT QUESTIONNAIRE

Please indicate, by underline, if you are registering the infant as the: birth mother/surrogate/legal adoption/father. If you are not the birth mother, we will need all of the information, as requested, from the birth mother before processing.

To be completed by BIRTH MOTHER

NAME: _________________________ D.O.B : ___________(mm/dd/yy) Height: _______ Weight: _______
BAF Insurance I.D. No: _________________ Hospital Delivered At: __________________________
Date of Admission: _______________(mm/dd/yy) Date of Discharge: ____________________(mm/dd/yy)

PREGNANCY: Please indicate conception method: ☐ Normal ☐ Hormonal Therapy ☐ IVF ☐ Surrogate ☐ Donor cells

Dates of Gestation: ______________(mm/dd/yy) thru ____________(mm/dd/yy)
General Health: Prior to pregnancy__________________ During Pregnancy: ________________
COMPLICATIONS: Have there been any problems during the pregnancy? Please tick. For example, but not limited to:

Hypertension______ Diabetes, Gestational Diabetes_______ Threatened abortion_____ STI's____ STD's____
VDRL_____ Heart Failure_____ Respiratory_______ UTI________ PET_______ Eclampsia_____ Seizures_____
Circulatory:___ Uterine__________ Genitourinary_______ Other___________

Blood Type______________ (indicate negative or positive)

Threatened labor: ☐ Yes ☐ No If yes, please state if you were admitted to hospital/bedrest and list prescription drugs you were given. ____

Did you have to consult with any other Physician/Specialist during the pregnancy? ☐ Yes ☐ No

If yes, please give details: ____

Prescription Medication: During Pregnancy_____________________ Post-natal (After delivery) ______________

Were there any complications during Labor and Delivery? ☐ Yes ☐ No
If yes, please give details: ____
Was Labor spontaneous or induced? ___________________
If induced, give reason: ____
Labor: Gestational Age: _______ weeks Length of time: Start_________ a.m./p.m. Delivery Time: ________ a.m./p.m.

Delivery: ☐ SVD (Vaginal Delivery) ☐ Cesarean Section, ☐ Emergency Cesarean Section (Please state reason):
____

Forceps Assisted: ☐ Yes ☐ No Vacuum Assisted: ☐ Yes ☐ No Complications: ☐ Yes ☐ No
Single or Multiple Births: If multiple births, give sex of each infant and time of birth separately:

Name of Newborn: ________________ Sex: ☐ M ☐ F Time of Birth: ____________a.m./p.m.
Name of Newborn: ________________ Sex: ☐ M ☐ F Time of Birth: ____________a.m./p.m.
Name of Newborn: ________________ Sex: ☐ M ☐ F Time of Birth: ____________a.m./p.m.
Name of Newborn: ________________ Sex: ☐ M ☐ F Time of Birth: ____________a.m./p.m.
Signed (birth mother): ____________________________ Date: _____________________(mm/dd/yy)

1/2022

NEWBORN(s)/INFANT(s)

(To be completed by Pediatrician)

In the case of multiple births, please complete a separate form for each infant.

Full name of Child: __________________Newborn Time of Birth: _______ a.m./p.m. Sex: ☐ Male ☐ Female

What is the gestational age? __________Where was infant born? Hospital's Name: __________________ Home: _______

How was the infant conceived? ☐ Normal ☐ Hormonal Therapy ☐ IVF ☐ Surrogate ☐ Donor cells

Newborn Resuscitation: None____ Free flow Oxygen_____ Suctioning____ Bag & Mask Ventilation ______

Intubation _____Cardiac Compressions______ Meconium Suctioning Protocol: _______________________

APGAR SCORE: __________ At 1 min ________At 5 mins. __________At 10 mins.

Obvious Congenital Anomalies: Head_____ Face______ Extremities_______ Chest________ Abdomen____

Back____ Spine ______Buttocks___________ Genitals_________ Digits_______

Birth weight: ________ Length: __________ cm Head Circumference: ____________Girth: ___________

During labor and delivery were there any notable signs of Fetal distress: Increased or Decreased Heart rate, Meconium-stained fluid, Meconium aspiration, Placenta Abruptio, Chord around neck etc.

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Were there any maternal/fetal anomalies? e.g. Oligohydramnios, Polyhydramnios, Large for dates, Small for Gestational Age, Fetal Chord defects, etc.

Was Infant admitted to NICU_____ Special Care_____ Nursery_______ DOA: ___________ DOD: _______________

Admission Diagnosis: ____

Treatment: ____

Based on the maternal medical history, labor and delivery episodes of the birth mother, is there any indication of birth defects or anomalies in the following areas:

Neurological/ CNS: ____

Cardiopulmonary: ____

Circulatory: ____

Sight: ____

Hearing: ____

Respiratory: ____

Gastrointestinal (Feeding): ____

Musculoskeletal: ____

Genitourinary: ____

MEDICAL NOTES:

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Signed: ________________________ Date: _____________________(mm/dd/yy)

Name: __________________________________ Stamp or Seal: