Awakening Wellness, LLC

Pediatric Birth History Form

Parent's Name: _____

Form Completed by: _____

Did Mother:

Have any infections/illness during pregnancy? Yes/No

Describe: _____

Have any shocks or unusual stress during pregnancy? Yes/No

Water break more than 24 hours before birth? Yes/No

Develop toxemia / high blood pressure? Yes/No When? _____

Have any complications during labor and/or delivery? Yes/No

What? _____

_____

Mother's age at delivery? ____

Any miscarriages? Yes/No How many? ____

CHILD'S BIRTH

Full Term? Yes/No

Premature? Yes/No How many weeks? _____

Birth Weight? _____

Apgar scores _____

Weight at discharge from hospital? _____

Cesarean section? Yes/No

Breech? (feet first) Yes/No

Face Presentation? Yes/No

Transverse (sideways) ? Yes/No

Cord wrapped around neck? Yes/No

Forceps used? Yes/No

Vacuum extraction? Yes/No

Birth Injuries? Yes/No Describe: _____

Require Fetal Monitor? Yes/No

Have enough oxygen? Yes/No

Cry right away? Yes/No

Was or did child:

Require hospitalization? Yes/No How long?

Need respirator? Yes/No How long?

Small for gestational age? Yes/No

Hear defect? Yes/No

Require transfusion? Yes/No

Jaundice? Yes/No How long under lights?

Have congenital abnormalities? Yes/No

Have seizures? Yes/No

Have infection at birth? Yes/No

Have surgery as newborn? Yes/No

Have feeding problems as newborn? Yes/No

Please provide any additional information you may deem helpful. (ie - mother's emotional state, family history, siblings, etc>