

NEWBORN OUTPATIENT RECORD

Date	Name	
Age	Birth Date	Mother's Name
Address		Phone No.
Hospital of Birth		

	Temp:	PKU		Length of Gestation	
Weight:	lb.	oz.	Head	cm.	In. Birth Weight: lb. oz.
Length:	In.		Chest	cm.	In. Birth Length: In.
				AGA	LGA
				SGA	

Informant:	Reliability:
Chief Complaint: (Nurse)	

Prenatal:

Delivery:

Neonatal: Jaundice, Cyanosis, Convulsions, Infections, Respiratory Distress,
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Other,	Specify:
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Feedings:

Elimination:

Family History:	Siblings:	Age	Health
Mother:	Age	Health	1)
Father:	Age	Health	2)
Other:	Age	Health	3)
			4)

Other Family History: (Indicate either YES or NO, and relationship of individual)		
Cancer	S.C. Anemia	Convulsions
Tuberculosis	Leukemia	Allergies
Diabetes	Rheumatic Fever	Kidney Trouble
Anemia	Heart Attacks	High B.P.

Medical Care Elsewhere	
Clinic	M.D.

Signatures	R.N.	M.D.
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