Child's Last Name First Middle Name Nick Name

Address: Street Number City County State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____

If you do not have a home or cell phone, is there a telephone number where you can be reached?

1. _____ _____
   Telephone Number Name of friend, relative, or location of phone

2. _____ _____
   Telephone Number Name of friend, relative, or location of phone

Mother's Name: _____

Father's Name: _____

Date: _____

Neonatal Clinic

coAge: _____ hnum _____ date _____ Name _____

Please list the doctors ***and other professionals*** who have seen or will be seeing your child. Please write their address or a phone number so we can send them a report.

	Name	Address/Phone Number	Dates	Reason
Primary Doctor				
Eye Doctor				
Dentist				
Service Coordinator or Therapist				
Other Specialists				

Has your child received ***early intervention*** or been in **daycare** or a **developmental center**? (list name, hours per week, date started)

_____

List your child's milk sources, other types of feedings, vitamins-iron and amounts per day

_____

Specific problems since we last saw your child (circle and explain):

ear infection * pneumonia * meningitis * seizures * accident or injury * surgery * hospitalization * other problem

Frequent or chronic problems your child has had more than once in the last 6 mo. (circle and explain):

Thrush * ear infections * vomiting / reflux * diarrhea * weight loss * breathing problem * other

_____

Medications (Rx) your child is taking (List Rx name and dosage):

_____

Special equipment (circle and explain how and when used):

apnea monitor * oxygen * suctioning * nebulizer * NG tube feedings * G-Tube * IV pump * orthopedic splints / braces
developmental equipment * special chair / stander * other:

_____

_____

Does anyone ***smoke*** in your home? (Explain): _____

February2019 MD initials_____

Health problems, ***concerns and review of systems*** (circle and explain) - or circle here if: **NO PROBLEMS**

skin: rash * birthmark * hair * nails * other _____

breathing: blue-spells * apnea * wheezing * croup * short of breath * cough * other _____

heart: murmur * irregular beat * heart failure * too fast * other _____

bowels: spitting * vomiting / reflux * diarrhea * constipation * stool blood * colic * other _____

nutrition: feeding problem * growth problem * weight loss _____

eyes: crossed (lazy) * vision-eyesight problem * discharge-crusting * other _____

ears: infection * hearing problem * other _____

nose/oral: snoring * congestion-drainage * teeth problem * white patches * other _____

genital: hernia * discharge * bleeding * genital development * painful urine * circumcision * other _____

bones: joint-swelling * hips * spine * foot-turning * orthopedic * fracture * other _____

behavior: sleep * crying * temper * discipline * toileting * hyperactive * other _____

changes: appetite * behavior * activity * sleep * losing developed skills * other _____

infections: bronchitis * urine * skin * joint * throat * "cold" * other _____

other: other problems * NICU complications _____

Family health conditions or problems in close relatives (circle and explain):

alcohol * mental illness * drugs * asthma * heart * vision * hearing * sickle-cell * anemia * arthritis * diabetes
cancer * tuberculosis * disability * HIV/AIDS * seizures * cerebral palsy * genetic * other

_____

Are there ***areas of development*** in which you think your child might be delayed? (circle and explain):

movement / coordination * hand use * thinking * language * eyesight * hearing * growth

_____

Is your child ***sick now*** or have a cold? Do you have ***specific questions or concerns*** about your child? (explain here and on the back):

_____
_

_____
_

_____
_

_____
_

_____
_

_____
_

MD initials_____

Please help by providing the following family information:

Guardian/Mother's Name:_____ Age: _____
(Circle): Single / Married / Separated / Divorced

Grade Finished in School? _____ Type of work that you do? _____

Home #:_____ Cell#:_____ text you? **YES / NO**

Email:_____ email you? **YES / NO**

Father's Name:_____ Age_____ Father lives in the home? **YES / NO**

Grade Finished in School? _____ Type of work? _____

Phone #: _____ Cell#_____

IF father or mother is not living in the home, how often does that parent see the baby? (circle)
At least once a week At least once a month Less than monthly Both parents live in the home

Additional Contacts: phone: _____ Name:_____

Maternal grandparent(s) phone:_____Name:_____
Address:_____ Town:_____State:_____Zip:_____

Paternal grandparent(s) phone:_____Name:_____
Address:_____ Town:_____State:_____Zip:_____

Type of home (Circle): Apartment / Mobile Home / House How many bedrooms? _____

Do you feel safe in your home? **YES / NO**

Does anyone smoke inside your home? **YES / NO**

Do you have any pets in your home? Type?_____

Do you use portable heaters in your home? **YES / NO**

How many people are living in your home? _____. Please list below the names, ages and any health problems of children living in your home:

Name	Age in years	Health Problems
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle the public assistance your family receives:

Medicaid / foodstamps / WIC / Social Security / Housing / daycare / other?_____

I don't qualify / I don't want it / I'm not sure I qualify

Do you ever miss medical appointments due to lack of dependable transportation? **YES / NO**

Do you feel like you have enough food for at least 2 meals per day? **YES / NO**

How many hours per week do others (besides you) care for your child _____ hrs/week

Do you care for your child daily in the home? **YES / NO**

Is your child enrolled in a daycare facility? **YES / NO** If so, how many hours per week? _____

Is your child enrolled in the **NC Infant Toddler Program** with the CDSA? **YES / NO** Hours per Month? _____

When was your child enrolled? _____ (month/year)

Coordinators Name: _____ Phone #: _____

Is your child receiving any therapy services to help with development? **YES / NO** Hours per week?_____

Do you plan on moving out of the area/state? **YES / NO** If yes, when? _____

Do you currently have any concerns / needs you need to discuss with the clinic social worker?

On Facebook? **YES / NO** Find Us at www.facebook.com/NeonatalFollowUpClinic

If you will need to change your appointments, please call (252) 744-4911. For more information please visit our website www.ecu.edu/pediatrics/neonatal