Medical History and Subjective Information Form
RNICU

Please answer the following questions. If you need help filling out this form, we would be happy to assist you.

Patient Name__________________________________ Birth Date: _______________ Today's Date: ________________

Pre-natal Maternal Conditions (Please check any conditions Mom had during pregnancy):

- ☐ Preeclampsia
- ☐ Gestational Diabetes
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Tobacco Use
- ☐ Oligohydramnios
- ☐ Polyhydramnios
- ☐ Bedrest
- ☐ Infection
- ☐ Seizure
- ☐ Cardiac Condition
- ☐ Trauma
- ☐ High Risk Pregnancy
- ☐ Placenta Previa
- ☐ Multiple Births

Pre-natal Fetal Conditions:

- ☐ Cerebral Vascular Accident
- ☐ Spina Bifida
- ☐ Two Vessel Cord
- ☐ Twin to Twin Transfusion Syndrome

Method of Delivery:

- ☐ Vaginal Delivery
- ☐ Scheduled C-Section
- ☐ Emergency C-Section
- ☐ Induction
- ☐ Forcep Assist
- ☐ Vacuum Assist

Complications During Delivery:

- ☐ Asphyxia
- ☐ Cerebral Vascular Accident
- ☐ Premature Labor
- ☐ Nuchal-Cord
- ☐ Brachial Plexus
- ☐ Precipitous Labor
- ☐ Cord Prolapse
- ☐ Seizure
- ☐ Fetal Distress

Past Medical History:

- ☐ Prematurity
- ☐ Hyperbilirubinemia
- ☐ Apnea of Prematurity
- ☐ Respiratory Distress Syndrome
- ☐ Chronic lung disease
- ☐ IVH
- ☐ Retinopathy of Prematurity
- ☐ Anemia of Prematurity
- ☐ Pulmonary Insufficiency
- ☐ Patent Ductus Arteriosus
- ☐ PVL
- ☐ Gastroesophageal Reflux
- ☐ Bronchopulmonary Dysplasia
- ☐ Thrombocytopenia
- ☐ Hernia
- ☐ Other:____

Physicians Currently Active in your Child's Care:

Name/Date	Name/Date
Family Doctor	Neurosurgeon
Gastroenterologist	Audiologist
Neurologist	Ophthalmologist
Cardiologist:	Pulmonologist:
Other:	

Diagnostic Test:

☐ x-ray ☐ CT Scan ☐ MRI ☐ Hearing ☐ Vision ☐ Other:_________________________________

Child Lives with: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Foster Parents ☐ Aunt ☐ Uncle ☐ Brother(s) #__ ☐ Sister(s) #__ ☐ Step-mother ☐ Step-father ☐ In Residential Facility ☐ Other

Adjunct Services:

- ☐ Early-On Physical Therapy
- ☐ Development Assessment Clinic
- ☐ Early-On Occupational Therapy
- ☐ Music Therapy
- ☐ Early-On Speech Therapy
- ☐ Infant Massage

Please check any of the following that apply to your child.

Previous Functional Level	**Yes**	**No**
Does your child lift their head from the floor while on their belly?	☐	☐
Does your child bring their hands to their mouth?	☐	☐
Does your child hold a rattle when you put it in their hand?	☐	☐
Does your child bat at objects in front of their face?	☐	☐
Does your child pivot in circles while on their belly?	☐	☐
Does your child roll from belly to back?	☐	☐
Does your child roll from back to belly?	☐	☐
Does your child sit without any support?	☐	☐
Does your child follow a moving object with their eyes?	☐	☐

Learning: (Please check any areas that your child is experiencing problems in):

Ability to Focus on Objects : ☐ Mom's Face ☐ Dad's Face ☐ Faces of others ☐ Toys

Behavior: ☐ Difficult to comfort ☐ Transitions poorly ☐ Prefers swaddling ☐ Wants to be held or walked much of the time ☐ Poor sleep/wake patterns

Interaction Skills: ☐ Difficulty interacting with familiar people ☐ Demonstrates stranger anxiety ☐ Prefers caregiver within sight ☐ Difficulty with handling and position changes