

**Birth History**

Hospital

Obstetrician

Pregnancy #

High Risk Pregnancy

Term? If no, # of weeks.

Delivery type(if C/S, indicate reason)

Delivery complication

Apgar Score

NICU(if Yes, indicate reason)

Birth weight and Length

Discharge weight and Date

Maternal Group B Strep

Maternal Hepatitis B (Pos, Neg or Unknown)

Hep B vaccine (date)

Bilirubin Screening (Blank if none; Transcutaneous and Serum if done)



**Maternal Blood Type**

**Infant Blood Type**

**Direct Coombs**

**Newborn Hearing screening done and NL?**

**Breast or Bottle**

**Other**

**Prescriptions**

**Visit Documents**

**Navigational Anchors in Birth History**

1. Prescriptions
2. Visit Documents