Newborn Questionnaire

Baby's Name:

How far along were you in your pregnancy at delivery? ________ weeks

Number of siblings child has: ____________________________

Ages of siblings:____

Does the child attend day care?

YES_____ NO_____

Is there any exposure to environmental air pollutants?

YES_____ NO_____

Is there a family history of asthma?

YES_____ NO_____

Is there any exposure to tobacco smoke?

YES_____ NO_____

Was the child's birth weight less than 5lbs 8oz.?

YES_____ NO_____

Does the child reside in crowded living conditions?

YES_____ NO_____

Have you had any multiples births? (ie- twins, triplets, etc.)

YES_____ NO_____

How far from a healthcare provider do you live?

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Any other risk factors/ Medical history

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