

Worksheet for Newborn's Birth Certificate

CHILD	Child's Name (first, middle, last) – Jr. etc.		Sex	Time of Birth	Date of Birth
	Street Address of Birth (home, birth center)		City, Town or Location		County
MOTHER	Mother's legal name (first, middle, last)			Date of Birth	
	Mother's maiden name			Birth Place (state, territory, country)	
	Residence of mother – State	County		City, Town or Location	
	Street and Number		Apt.	Zip Code	Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No
FATHER	Father's Name (first, middle, last)		Date of Birth	Birth Place (state, territory, country)	

CERTIFIER	Certifier's or Attendant's Name
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MOTHER	Mother's Mailing Address Same as Residence? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Mailing Address if different from residence		City	State	Zip
	Mother Married (at birth, conception or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, has paternity acknowledgement been signed? <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security # for Child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Mother's Social Security Number		Father's Social Security Number		

FATHER	Race (white, American Indian, Black, etc.)	Origin or Descent (Mexican, Puerto Rican, German, etc.)	Education Primary (0-12) College (1-5) +
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MOTHER	Race (white, American Indian, Black, etc.)	Origin or Descent (Mexican, Puerto Rican, German, etc.)	Education Primary (0-12) College (1-5) +
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Date of last normal menstrual period _____	Total prenatal visits _____
Month of pregnancy prenatal care began _____	Mother's primary occupation _____

THIS BIRTH	First Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Weight	Apgar Scores 1 min. 5 min.	Gestational Age	History of Childhood Deafness in family? <input type="checkbox"/> Yes <input type="checkbox"/> No
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PREVIOUS PREG.	LIVE BIRTHS	TERMINATIONS	Mother Transferred prior to delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No
	# Living _____ <input type="checkbox"/> None	Spontaneous # _____	If yes, where _____
	Now Dead # _____ <input type="checkbox"/> None	Induced # _____	Infant transferred <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last live birth _____	Date of last termination _____	If yes, where _____	

<p>MEDICAL RISK FACTORS FOR THIS PREGNANCY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia (Hct. < 30 / Hgb. < 10) <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Acute or chronic lung disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Genital herpes <input type="checkbox"/> Hydramnios/Ogliohydramnios <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> Hypertension, chronic <input type="checkbox"/> Hypertension, pregnancy related <input type="checkbox"/> Eclampsia <input type="checkbox"/> Incompetent cervix <input type="checkbox"/> No prenatal visits <input type="checkbox"/> Previous infant 4000 + grams <input type="checkbox"/> Previous preterm, SGA or < 2500 g <input type="checkbox"/> Renal disease <input type="checkbox"/> Rh sensitization <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Syphilis <input type="checkbox"/> Rubella <input type="checkbox"/> None <input type="checkbox"/> Other _____ <p>OTHER RISK FACTORS FOR THIS PREGNANCY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tobacco use? <input type="checkbox"/> Avg. # of cigarettes/day _____ <input type="checkbox"/> Alcohol use? <input type="checkbox"/> Avg. # drinks/week _____ <input type="checkbox"/> Weight gained _____ <p>OBSTETRIC PROCEDURES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Electronic fetal monitoring <input type="checkbox"/> Induction of labor <input type="checkbox"/> Stimulation of labor <input type="checkbox"/> Tocolysis <input type="checkbox"/> Ultrasound <input type="checkbox"/> None <input type="checkbox"/> Other 	<p>COMPLICATIONS OF LABOR or DELIVERY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Febrile (> 100°F or 38°C) <input type="checkbox"/> Meconium, moderate/heavy <input type="checkbox"/> Premature rupture of membranes <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placenta previa <input type="checkbox"/> Other excessive bleeding <input type="checkbox"/> Seizures during labor <input type="checkbox"/> Precipitous labor (< 3 hours) <input type="checkbox"/> Prolonged labor (> 20 hours) <input type="checkbox"/> Dysfunctional labor <input type="checkbox"/> Breech / Malpresentation <input type="checkbox"/> Cephalopelvic disproportion <input type="checkbox"/> Cord prolapse <input type="checkbox"/> Anesthetic complications <input type="checkbox"/> Fetal distress <input type="checkbox"/> None <input type="checkbox"/> Other <p>METHOD OF DELIVERY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal <input type="checkbox"/> VBAC <input type="checkbox"/> Primary C-Section <input type="checkbox"/> Repeat C-Section <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Version and Extraction <p>ABNORMAL CONDITIONS OF THIS NEWBORN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia (hct. < 39 / Hbg. < 13) <input type="checkbox"/> Injury occurring during birth <input type="checkbox"/> Fetal alcohol syndrome <input type="checkbox"/> Hyaline membrane distress / RDS <input type="checkbox"/> Meconium aspiration syndrome <input type="checkbox"/> Assisted ventilation < 30 mins. <input type="checkbox"/> Assisted ventilation > 30 mins. <input type="checkbox"/> Seizures <input type="checkbox"/> None <input type="checkbox"/> Other 	<p>CONGENITAL ANAMOLIES of CHILD</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anencephalus <input type="checkbox"/> Spina bifida / Meningocele <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Microcephalus <input type="checkbox"/> Other CNS anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Heart malformations <input type="checkbox"/> Other circulatory / resp. anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Rectal atresia / stenosis <input type="checkbox"/> Tracheo-esophageal fistula / atresia <input type="checkbox"/> Omphalocele / Gastroschisis <input type="checkbox"/> Other gastrointestinal anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Malformed genitals <input type="checkbox"/> Renal agenesis <input type="checkbox"/> Other urogenital anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Cleft lip / palate <input type="checkbox"/> Polydactyly / Syndactyly / Adactyly <input type="checkbox"/> Club Foot <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Other musculoskeletal/integumental anomalies _____ <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> Down's syndrome <input type="checkbox"/> Other chromosomal anomalies <hr/> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Other
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