NEWBORN QUESTIONNAIRE-1st WEEK

**Who lives in the household (ex. Mother, brother)?_____
Do you have any concerns today for your baby?_____

How many weeks were you at delivery (ex. 35-39 or full-term)?_____

Did you have any problems during pregnancy or complications at delivery?_____

Was the delivery by C-section or a Vaginal Delivery?_____

How many lbs. did the baby weigh at birth?_____ How many inches long?_____

Did the baby stay in nursery due to problems (i.e. Jaundice, heart rate, feeding)?_____ If yes, list problem please._____

If hearing screen was done, did she pass?_____ Did she receive Hep B shot?_____

Did the baby have to have surgery?_____ If male, was he circumcised?_____

What formula is the baby drinking or is it breast fed?_____ If formula, please list formula name_____. It feeds _____ounces every____ hour(s).

Is he/she pooping and peeing well?_____

Is he/she sleeping ok at night?_____ Does he/she wake to eat?_____ How many times?_____

Is he/she a good natured or fussy baby?_____ If fussy, list why:_____

Does he/she lift head about 45 degrees (little less than half-way)? _____

Can he/she grasp a hand or palm?_____

Can he/she follow with their eyes halfway to each side?_____

Does he/she move arms and legs equally good, full stretch?_____

Does he/she like to cuddle?_____

Does he/she recognize faces of others(includes parents, family.)?_____

Does he/she vocalize/squeal or coo ?_____Does he/she smile?_____ Is the smile out of the blue(while sleeping) or is it responsive?_____

Does he/she regard her face and hand(put in mouth and touch face?_____

Does he/she respond to sound (i.e. bells, tv, slammed doors)?_____

Does he/she cry out without reason at time, whining or crying?_____
Does anyone smoke around him/her?_____

Any pets in the home_____

Any guns in the home_____

Any excessive sun exposure_____

NEWBORN QUESTIONNAIRE-1st WEEK

Is your home child proofed_____

Is the child using a car seat_____

Does your home have smoke detectors_____

Does your home have fire extenguishers_____

Any concerns with vision or hearing_____

Are parents coping well_____

Can the baby say ooh and ahh_____

Does your child sleep on his back_____

When the patient has a bm is it yellow and seedy._____

Does it have a bm every feed or every other feed_____ or how many times a day does he/she have a bm_____

Does the patient urinate every feed or every other feed._____

2nd PART-FAMILY HISTORY? Underline any that apply to your family history on both sides (mom/dad)(siblings,parents, grandparents) of problems ? (i.e. Diabetes, High Blood Pressure, Cancer, Seizures, Migraines, Asthma, Thyroid Disease, Kidney problems, Arthritis, Heart Disease, Stroke, High Cholesterol, Learning Disabilities, ADHD/ADD, Depression). Please write which of your family members has the condition._____