Newborn Well Child Questionnaire

Name _____

DOB _____

Chief Complaint

Please circle or print appropriate answer

Do you have any concerns about your baby?

Yes No

If so, explain _____

Does your baby have any special health care needs?

Yes No

If so, explain _____

Has your baby seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

If so, explain _____

Has your baby had any procedures or tests done since your last visit?

Yes No

If so, explain _____

How are you adjusting to the baby?

Well Fair Poor

In the last 2 weeks, has the mother been feeling down, sad, hopeless, or overwhelmed? Does the mother have little interest or pleasure in doing things?

Not at all Several days More than half the days Nearly every day

Who helps to take care of the baby or household chores? _____

How are the baby's siblings adjusting to the baby?

N/A Well Fair Poor

How many people, other than this baby, are living in this baby's home?

Please select all that apply

Mother Father Sibling(s) Significant Other of Mother Significant Other of Father Maternal Grandparent(s) Paternal Grandparent(s) Other Family Member(s) Friend(s)

If this baby is not living with both biological parents, what is the living situation?

Joint Custody Single Custody Family Member Foster Home Adoptive Home Other

If other, explain _____

Besides your baby's birth, have there been any other major changes in your family?

Yes No

What kind of change?

Separation Divorce Move Return to Work/School Job change Loss of job Money problems Significant Illness Death in the Family Other

If other, explain _____

What are your plans for work?

Please select all that apply

Mother staying home Mother returning Father staying home Father returning

What are your plans for childcare?

Family Member Babysitter/Nanny Daycare

When will child care start?

_____/_____/_____(mm/dd/yyyy)

Does your baby live with anyone or spends time with anyone who smokes? Does anyone smoke in the care your baby travels in?

Yes No

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Review of Systems Please circle or print appropriate answer

Is your baby breastfeeding?

Yes breastmilk only Yes Breastmilk supplemented by formula No

If breastfeeding how many minutes does your baby breastfeed per feeding? _____

How many feedings per day? _____

Have you been having any problems with breastfeeding? _____

Is your baby drinking formula?

Yes Formula only Yes formula supplement for breastfeeding No

How many ounces of formula does your baby drink per feeding? _____

How many feedings per day? _____

What brand of formula does your baby drink? _____

What kind of water do you use to mix with the formula?

Tap Well Bottled Ready-to-Feed

Is the formula your baby drinks iron-fortified?

Yes No Unknown

Does your baby drink anything else besides breast milk or formula?

Yes No

Do you know when your baby is hungry?

Yes No

Do you know when your child is full?

Yes No

Does your baby have any problems with feeding?

Yes No

If so describe _____

Do you have difficulty with burping your baby?

Yes No

Do you have concerns that your baby is frequently vomiting, throwing up, or spitting up?

Yes No

How many times a day does your child vomit, throw up, or spit up? _____

Do you have concerns about your baby's weight?

Yes No

Does your baby take vitamins or supplements?

Yes No

If so, describe _____

How many wet diapers does your baby have per day

Less than 6 6-8 More than 8

How many bowel movements does your baby have per day?

Less than 3 3-4 More than 4

How many hours does your baby sleep per day? _____

When does sleep occur?

Between feedings Mostly during the day Mostly at night

Is your baby put to sleep on their back?

Yes No

Does your baby sleep in their own crib or bed?

Yes No

Is your child's bed in a caregiver's room?

Yes No

Has your baby had any redness, odor, or discharge form their umbilical cord?

Yes No

Do you have questions on how to check your baby's temperature rectally?

Yes No

Do you have concerns about your baby's vision?

Yes No

If so, describe _____

Do you have concerns about your baby's development?

If so, describe _____

Do you have concerns about your baby's behavior?

If so, describe _____

When your baby rides in a car, do you use a car seat?

Every time Occasionally Never

Where in the car, is the car seat located?

Front seat Back seat

Which way is the car seat facing?

Forward Rear

Do you know when to call your baby's doctor?

Yes No

Do you have a list of emergency numbers that are easy to find?

Yes No

Is your baby left alone in the tub or in high places?

Yes No

Does your baby weal jewelry or a pacifier around their neck?

Yes No

Is the temperature of your hot water at or below 120 degrees Fahrenheit in the places your baby frequents? (For example, at home, at babysitter's, or daycare)

Yes No