PT ID: _____ Patient's Name: _____

PCP: _____ Date of Birth: _____

Today's Date: _____

# Newborn Parent Observations

**Are there any concerns you would like to discuss today?** _____

_____

**Birth History:**

Where did you deliver? _____

Any pregnancy or delivery complications?

_____

Vaginal or C-section delivery? _____

What was your estimated due date? _____

Birth weight: _____ Length: _____

Any complications after delivery? (such as jaundice, infection, low blood sugars) _____

_____

Please check all that apply:

- ☐ Received erythromycin eye ointment
- ☐ Received Vitamin K injection
- ☐ Received Hepatitis B vaccine
- ☐ Passed Hearing Screen
- ☐ Passed Heart Screen (CCHD)
- ☐ Received Tdap vaccine during pregnancy
- ☐ Received Flu vaccine during pregnancy

**Breast Feeding:**

Number of feeding per day: _____ per night: _____

Infant takes _____ minutes per feeding per breast.

Any breast-feeding difficulties? ..... YES NO

Are you giving Vitamin D drops daily? ..... YES NO

**Formula Feeding**:

Formula name _____ With iron? ..... YES NO

Number of feedings per day: _____ per night: _____

Number of ounces per feeding: _____

Do you have any questions regarding formula? ..... YES NO

**Voiding/Stooling**:

Approximate number of wet diapers per 24 hours: _____

Approximate number of stools per 24 hours: _____

Quality of stools (please circle one): Black/Tarry Brown Yellow/Green

***PLEASE COMPLETE OTHER SIDE***

**Sleep**:

How many uninterrupted hours of sleep at night (i.e. in between feeds)? _____

How many naps per day? _____ How long is each nap? _____

Is your child sleeping on his/her back? ..... YES NO

Is your child sleeping in a (please circle one): Bassinet Crib Co-Sleeping

Are family members and siblings (if any) doing well with the baby? ..... YES NO

Does your baby use a rear-facing car seat 100% of the time? ..... YES NO

***Car Seat Assistance and Inspection: 801-662-CARS (2277) at Primary Children's Hospital***

Is your baby exposed to smoking in the home? ..... YES NO

Do you know how to take your baby's temperature and what a normal temp is? ..... YES NO

***Call our office promptly if your infant is younger than 3 months and has a fever over 100.4 $^{o}$***

**Family History**

Mother's age: _____ Occupation: _____

Any health problems? _____

Father's age: _____ Occupation: _____

Any health problems? _____

Parents are (please circle): married divorced separated other

Child lives with (please circle): mother father both other

Please list other children (oldest first) and any health/emotional problems:

| Name | Age | Problems |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please note a relationship to your child of any blood relatives who had any of the following**:

Birth defects/malformations _____

Crib death/SIDS _____

High blood pressure _____

Death before age 1 _____

Kidney disease _____

Mental disabilities _____

Deafness _____

Diabetes _____

Bedwetting _____

Other _____

Heart disease before age 60 _____

Asthma/hay fever/eczema _____

Strokes _____

Liver disease _____

Seizures _____

Tuberculosis _____

Blindness _____

School problems _____

High cholesterol _____