Patient ID_____ Patients Name_____

PCP_____ DOB_____

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 you 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 feedings 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

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 choose 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 care 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°

******Please Complete Other Side******

Family History:

Mother's Age _____ Occupation _____ Any Health Problems? _____

Father's Age _____ Occupation _____ Any Health Problems? _____

Parents marital status: (Please choose one) Married Divorced Separated Other

Child lives with: (Please choose one) Mother Father Both Other

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

Name	Age	Health/Emotional Problems

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

Birth Defects/Malformations _____ Heart Disease before age 60 _____

Crib death/SIDS _____ Asthma/Hayfever/Eczema _____

High Blood Pressure _____ Stroke _____

Death before age 1 _____ Liver Disease _____

Kidney Disease _____ Seizures _____

Mental Disability _____ Tuberculosis _____

Deafness _____ Blindness _____ Diabetes _____

School Problems _____ Bedwetting _____

High Cholesterol _____ Other _____