



PT ID:
PCP:
Today's Date:

Patient's Name:
Date of Birth:

2 Week Old Parent Observations

Are there any concerns you would like to discuss today?

Breast Feeding (if applicable):

Number of feedings per day: per night:
Infant takes minutes per feeding
Any breast-feeding difficulties? YES NO
Are you giving Vitamin D drops? YES NO

Formula Feeding (if applicable):

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: Liquidy/Seedy Soft/Mushy Hard pellets

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: Bassinet Crib Co-Sleeping in bed with parent

Development:

Does your child: (check all that apply)
move all extremities fix eyes briefly on object
wake for feedings able to be calmed
raise his/her head focus on your face
grasp your finger when placed in palm react to noise

If parent(s) plan to return to work, who will be caring for your child?

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 home/car a smoke-free environment? 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°

If this is your child's first visit to our office, please also complete the Birth History portion of the
'Newborn Parent Observations' available from the front desk. Thank you!