UW Medicine
PRIMARY CARE

Newborn Well Child Visit

Baby's Name_____ Baby's Age_____ Date_____

Person completing the form_____ Relationship to the patient_____

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

Perinatal History:	**Yes**	**No**
Was your baby born on time?	( )	( )
Were there any problems during your pregnancy?	( )	( )
Were there any problems or complications during/after delivery?	( )	( )
Was your baby breech at any point during your pregnancy?	( )	( )
Did your baby need oxygen or antibiotics?	( )	( )
Did your baby receive the first hepatitis B shot?	( )	( )
Did your baby pass a hearing test?	( )	( )

Nutrition:	**Yes**	**No**
What was your baby's birth weight? _____		
Weight at hospital discharge, if known? _____		
Is your baby feeding well?	( )	( )
Is your baby breastfed?	( )	( )
• If yes, how often? _____		
Are you offering anything else to your baby to eat or drink?	( )	( )
Is your baby formula fed? If yes:	( )	( )
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		

Family and Social History:	**Yes**	**No**
Are there any major illnesses in the family?	( )	( )
Who lives in the home with you?		
Do you feel that you have enough support from friends/family/each other?	( )	( )
Are you having a hard time adjusting to your new situation?	( )	( )

Preventative Health/Risk Factors:	**Yes**	**No**
Does your child sleep only on his/her back?	( )	( )
Do you have a crib or bassinet for your baby?	( )	( )
Does your child always ride in a car seat, in the back seat, facing backwards?	( )	( )
Do you, anyone who cares for your child, or anyone in your home smoke?	( )	( )
Are there smoke detectors and fire extinguishers in your home?	( )	( )
• If yes, are they checked yearly?	( )	( )
	( )	( )
Do you have a thermometer?	( )	( )

Behavioral/Mental Health:	**Yes**	**No**
How would you describe your child's temperament?		
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
• If yes, do you need assistance to find a suitable program?	( )	( )

Developmental Surveillance:	**Yes**	**No**
Communicative: Turns and calms to your voice?	( )	( )
Cognitive: Follows your face with his/her eyes?	( )	( )
Physical Development: Lifts head when on tummy?	( )	( )
Can suck, swallow, and breathe easily?	( )	( )