

# 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)

<b>Perinatal History:</b>	<b>Yes</b>	<b>No</b>
Was your baby born on time?	<input type="checkbox"/>	<input type="checkbox"/>
Were there any problems during your pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Were there any problems or complications during/after delivery?	<input type="checkbox"/>	<input type="checkbox"/>
Was your baby breech at any point during your pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Did your baby need oxygen or antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>
Did your baby receive the first hepatitis B shot?	<input type="checkbox"/>	<input type="checkbox"/>
Did your baby pass a hearing test?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Nutrition:</b>	<b>Yes</b>	<b>No</b>
What was your baby's birth weight? _____		
Weight at hospital discharge, if known? _____		
Is your baby feeding well?	<input type="checkbox"/>	<input type="checkbox"/>
Is your baby breastfed?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, how often? _____		
Are you offering anything else to your baby to eat or drink?	<input type="checkbox"/>	<input type="checkbox"/>
Is your baby formula fed? If yes:	<input type="checkbox"/>	<input type="checkbox"/>
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		

<b>Family and Social History:</b>	<b>Yes</b>	<b>No</b>
Are there any major illnesses in the family?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having a hard time adjusting to your new situation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel that you have enough support from friends/family/each other?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having a hard time adjusting to your new situation?	<input type="checkbox"/>	<input type="checkbox"/>

PLACE PATIENT LABEL HERE

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Harborview Medical Center – University of Washington Medical Center  
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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

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

<b>Developmental Surveillance:</b>	<b>Yes</b>	<b>No</b>
<b>Communicative:</b> Turns and calms to your voice?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cognitive:</b> Follows your face with his/her eyes?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Physical Development:</b> Lifts head when on tummy?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having a hard time adjusting to your new situation?	<input type="checkbox"/>	<input type="checkbox"/>

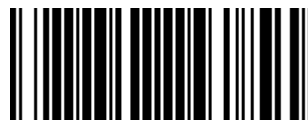
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