Newborn Check Up - Parent's Page

Name:	Brought in by:	Date:
Allergies:	Medicines:	Phone number:

About Your Baby's Family:

Baby's mother's name and age:_____

Baby's father's name and age: _____

How many pregnancies has baby's mother had _____ and how many children? _____

How many children has baby's father had? _____

Names and ages of baby's brothers and sisters (half and full siblings)? _____

_____

Who lives with your baby? _____

About Pregnancy and Birth:

What medications did baby's mother take in this pregnancy? _____

Did baby's mother have medical problems during this pregnancy?_____

Tell me about baby's birth?
How many weeks along was baby's mother? _____ Was it vaginal? _____ Or a C-section? _____

Was labor induced? _____If so, why? _____

Were there complications? _____

What medicine was mother given in labor? _____ Did mother have an epidural? _____

Do you have any concerns about what happened during labor or baby's birth?

_____

About Your Baby:

Do you have any concerns about your baby?

_____

Please tell me about your baby's sleeping: _____

How are you feeding your baby? Any problems? _____

Does your baby cry a lot? How easily is your baby soothed? _____

_____

Baby's safety and welare:

Does your baby ride in a rear-facing car seat in the back seat?	yes	no	sometimes
Does you baby sleep on his or her back?	yes	no	sometimes
Do you feel confident in bonding with your baby?	yes	no	maybe

How are you doing? (please circle)

I have been anxious or worried for no good reason:

Not at all Hardly ever Yes, sometimes Yes very often

I have felt scared or panicky for no good reason:

Yes, quite a lot Yes, sometimes No, not much No, not at all

I have blamed myself unnecessarily when things went wrong:

Yes, quite a lot Yes, sometimes No, not much No, not at all

Family history:

Please write is any medical problems in baby's family – consider these problems:

high blood pressure	thyroid issues	anxiety	seizures
high cholesterol	liver disease	alcoholism	spina bifida
heart disease	kidney disease	drug addiction	birth defects
smoking	skin issues	vision issues	cystic fibrosis
asthma	arthritis	hearing problems	hemochromotosis
diabetes	inflammatory bowel	learning disabilities	other inherited problems
obesity	depression	ADHD	other childhood illnesses or cancers

Mother:_____

Father: _____

Brothers: _____

Sisters: _____

Mother's mother: _____

Mother's father: _____

Father's mother: _____

Father's father:_____

Your baby's aunts or uncles: _____

Your baby's first cousins: _____

Anyone else: _____

Newborn Check Up - Doctor's Page

Name:_____Age: _____Date: _____

Vaccines given today: □ other: _____

□ See vaccine registry for vaccine administration details
□ Prior reaction and immunizations reviewed and explained, VIS given

Reminders:

□ Hearing test passed

□ Hep B received and in registry

□ Metabolic screen normal

□ Birth records reviewed

Physical exam: (check if normal)

□ see EMR for vitals and growth charts

□ General appearance
□ Head (□ fontanels)
□ ENT (□ palate intact)
□ Heart (□ femoral pulses)
□ Genitalia (□ descended testes, □ circ)
□ Skin (□ no jaundice)
□ Eyes (□ red reflex □ EOM □ cover/uncover)
□ Lungs
□ Abdomen (□ umbilicus)
□ Extremities (□ hips)
□ Neurological (□ milestones consistent with history)
□ Parent child interaction

Assessment:
□ well baby - no concerns
□ back to birth weight □ not back to birth weight but gaining well

Plan:
□ weight check in one week □ scheduled
□ follow up 1 months for WCC - no vaccines □ scheduled
□ WIC referral
□ registration papers given

Topics discussed:
□ Family history
□ Postpartum depression

□ Newborn visit hand outs given after reviewing with patient:

Signature: _____