

Patient Questionnaire – Newborn Well Child

Patient Name: _____ Date of Birth: ___/___/___ Date: _____

History Provided By (please circle)	Mother	Stepparent	Grandmother	Aunt		
	Father	Brother	Grandfather	Foster Parent		
	Legal Guardian	Sister	Uncle	Caseworker		
Lives With (please circle)	Mother	Stepparent	Grandmother	Aunt		
	Father	Brother	Grandfather	Foster Parent		
	Legal Guardian	Sister	Uncle	Caseworker		
Interval Problems (please circle)	Caregiver depression	Lack of social support	Recent illness			
	Caregiver stress	Marital discord	Recent injury			
	Chronic caregiver stress at home					
Nutrition						
Milk Source (please circle)	Breastfeeding	Cow's Milk	Formula			
Additional Intake (please circle)	Solids	Water	Non-nutritional			
Breast Feeding						
Frequency of Feedings (please circle)	Every 1-3 hours	Every 6-8 hours	5-8 times per 24 hours			
	Every 4-5 hours	1-4 times per 24 hours	9-12 times per 24 hours			
Side per Feeding (please circle)	One side	Both sides				
Feeding time per side (minutes) (please circle)	Right breast:	1-5	6-10	11-15	16-20	20+
	Left breast:	1-5	6-10	11-15	16-20	20+
	Ounces per 24 hours:	_____				

Please see reverse side

Breast Feeding Cont.	
Pumped (please circle)	Yes No
Formula	
Type of Formula (please circle)	Cow's milk based Low Iron Premature Extensively Hydrolyzed Metabolic Soy Lactose Free Ounces per Feeding: _____ Ounces per 24 hours: _____
Frequency of Feedings (please circle)	Every 1-3 hours Every 6-8 hours 5-8 times per 24 hours Every 4-5 hours 1-4 times per 24 hours 9-12 times per 24 hours
Cereal	
Cereal Type (please circle)	Barley Corn Oat Rice
Feeding Problems (please circle)	Burping Poorly Spitting Up Vomiting
Elimination	
Urinary Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours With every feeding 1-3 times per 24 hours More than 6 times per 24 hours
Stool Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours Once per 48 hours 1-3 times per 24 hours With every feeding Once per 72 hours 4-6 times per 24 hours
Stool Consistency (please circle)	Formed Hard Loose Seedy Watery
Elimination Problems (please circle)	Colic Diarrhea Urinary Symptoms Constipation Gas

Sleep			
Sleep Location (please circle)	Bassinet	Crib	Parent's Bed
How child falls asleep (please circle)	Bottle is in crib In caretaker's arms	In caretaker's arms while feeding	On own
Sleep Position (please circle)	Supine (on back)	On side	Prone (on stomach)
Average sleep duration in hours: _____			
Safety/Environment			
Home is child-proofed (please circle)	Yes	No	Partially
Smoking in home (please circle)	Yes	No	
Working smoke alarms (please circle)	Yes	No	Don't know
Working CO (carbon monoxide) alarms (please circle)	Yes	No	Don't know
Car seat (please circle)	Yes	No	
Screening			
Immunizations up-to-date (please circle)	Yes	No	
Neonatal screens normal (please circle)	Yes	No	
Social			
Caregiver enjoys child (please circle)	Yes	No	
Childcare location (please circle)	Child's home	Daycare	Another residence
Childcare provider (please circle)	Parent	Relative	Babysitter Daycare provider
Days per week at daycare: _____			
Hours per day at daycare: _____			

Growth and Development

Do you or your family have concerns about your baby's development or behavior? (please circle)

Yes No

Does your baby:

Focus on faces? (please circle)

Yes No

Move arms and legs the same on right and left sides? (please circle)

Yes No

Respond to sound? (please circle)

Yes No

Lift head briefly when lying on tummy? (please circle)

Yes No