Newborn (1-2 week) Well Child Check Name_____

Allergies_____ Current Medications_____

Pregnancy/Delivery

DOB/Time_____Due date?_____Type of birth_____Breech?_____

Birth Weight_____Place of Birth_____Discharge Weight_____

Discharge Bilirubin_____# of pregnancies_____# of children_____

Complications during pregnancy?_____ _____

Complications during delivery?_____

Complications with baby after delivery?_____

What was result of mothers Group B strep test?	Positive	Negative	Unknown
Does your baby sleep on his/her back?	Yes	No	
Where does your baby sleep?	_____		
Is your hot water heater turned down to less than 120 degrees?	Yes	No	
Does your house have smoke detectors?	Yes	No	
Do you have working carbon monoxide detectors?	Yes	No	
Did your baby have the Hepatitis B vaccine in the hospital?	Yes	No	
Did your baby get a Vitamin K shot after birth?	Yes	No	
Is your baby in good health?	**Yes**	**No**	
Is the delivery record in the chart	Yes	No	
Did your baby pass the hearing screen?	Yes	No	
Do you think your baby can see?	Yes	No	
Is your baby having at least one stool/day?	Yes	No	
Has your baby had at least 3 wet diapers in the past 12 hours And, if a boy, does he have a strong stream?	Yes	No	
Does your baby sleep most of the day with a few periods of wakefulness?	Yes	No	
Does your baby cry excessively?	**No**	**Yes**	

Does your baby have skin problems? No Yes _____

Feeding

If you are breastfeeding, is it going well? Yes No

How often is your baby feeding? Every _____Hours

If you are giving formula, are feedings going well? Yes No

What type of formula and ounces/feeding**?_____**

Does your baby take a vitamin/supplement? Yes No

Do you feel depressed or do you have a past history of depression? No Yes_____

Have there been any recent changes in your family structure? No Yes_____

Were there any prenatal complications? No Yes_____

Does your home have a safe, adequate heat source? Yes No _____

Does anyone in your household smoke? No Yes _____

Do you have any concerns?

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