OPTUM®

Department of Pediatrics
1-719-522-1134 TTY **711**

Well-check questionnaire

Newborn well-check

Patient name: _____ **DOB:** _____ **Today's date:** _____

Medications: _____ **Allergies:** _____

Mother's maiden name: _____

Birth date: _____ Birth hospital: _____ Type of delivery: _____

Discharge date: _____ Birth weight: _____ Mom's blood type: _____

Due date: _____ Discharge weight: _____ Baby's blood type: _____

Result of Group B Strep test before delivery: Positive Negative Unknown

Any complications during pregnancy?	☐ No	☐ Yes
Any complications with labor and delivery?	☐ No	☐ Yes
Any complications with the baby after delivery?	☐ No	☐ Yes
Did your baby get the Hepatitis B shot in the hospital?	☐ No	☐ Yes
Did your baby pass a hearing test?	☐ No	☐ Yes

Of wet diapers a day: _____ # Of stools a day: _____

Are you breast or formula feeding? _____

Name of formula: _____ Ounces per feeding: _____

Is your baby eating at least every three hours?	☐ No	☐ Yes
Are you having difficulty feeding your baby?	☐ No	☐ Yes
Does your baby sleep in a crib or bassinet?	☐ No	☐ Yes
Do you use a car seat?	☐ No	☐ Yes
Is the baby sleeping on his/her back?	☐ No	☐ Yes
Is your hot water heater turned down to 120°?	☐ No	☐ Yes
Does your home have smoke detectors?	☐ No	☐ Yes
Does your home have carbon monoxide monitors?	☐ No	☐ Yes
Do you feel depressed or have a family history of depression?	☐ No	☐ Yes
Is your baby exposed to secondhand smoke at home, in cars or at daycare?	☐ No	☐ Yes

Is your baby:

Quick to agitation?	☐ No	☐ Yes
Difficult to soothe?	☐ No	☐ Yes
Irritable with feeding?	☐ No	☐ Yes

Any questions or concerns: _____