Name: _____ Date of birth: _____

Newborn Questionnaire

Mother's name: _____ Date of birth: _____Occupation: _____

Mother's maiden name: _____

Father's name: _____ Date of birth: _____ Occupation: _____

Baby lives with: mother father mother&father other:_____
# of siblings: 0 1 2 3 4 other: __, names of siblings: _____
_____

Planned childcare: daycare babysitter stays at home other:_____

Passive smoke exposure: Y N Car seat use: Y N
Smoke detectors: Y N Fire extinguishers: Y N

Birth history:
Hospital: _____ Gestation: _____ weeks
___ vaginal ___ C-section ___forceps ___ vacuum

Birth weight: _____ Length: _____ Apgars: _____
Discharge date: _____ Discharge weight: _____ Jaundice: Y N

Blood type: mom _____ baby _____ Hearing screen: passed failed
Hepatitis B vaccine given in hospital: Y N

Pregnancy problems: Y N _____

Newborn complications: Y N _____

Feeding history:
Breastfeeding? Y N Every ____ hours For _____ minutes per side
Formula feeding? Y N Formula:_____ , ____ oz every ____ hours
Any problems feeding? Y N _____

Stool pattern: 1X/day 2X/day several/day soft runny hard

Sleep problems: Y N _____

Family history:
Childhood deaths, who? _____ Cancer, who?_____ Allergies, who? _____
Psychiatric disorder, who? _____ Seizures, who?_____ Cystic fibrosis, who? _____
Learning disability, who? _____ Diabetes, who? _____ Deafness, who? _____
Heart problems, who?_____ Asthma, who? _____ Sickle cell, who? _____
Thyroid problem, who? _____ eczema, who? _____ other:_____

Do you have any concerns about your baby? _____

Updated 8/28/17