Woodinville Pediatrics Newborn Questionnaire

Birth Hospital: _____ Weeks Gestation: _____
Birth: ___ Vaginal ___ C-Section
Birth Weight (lbs) _____ Birth Weight (ozs) _____ Breech Presentation: ___ Yes ___ No
Passed Hearing Screen : ___ Yes ___ No
Hep B Vaccine Administered? : ___ Yes ____ No
Ultrasound Abnormal: ____ Yes ____ No

**Parental concerns this visit:** _____

**Current medications** _____

**Development**
Social Emotional: Eats Well: ____ Yes ____ No
Communication: Turns and calms to your voice : ____ Yes ____ No
Cognitive: Follows your face: ____ Yes ____ No
Development: Can suck, swallow, and breathe easily: ____ Yes ____ No

**Family**
Concerns about maternal depression: ____ Yes ____ No
Reactions of siblings to new child _____
Work plans _____
Child Care Plans _____

**Diet**
Milk _____
Type: _____
Amt/Time per feeding _____
Frequency _____
Vitamin A/D/C : ____ Yes ____ No
Comments: _____

**Bowel/Bladder**
Stool Concerns: ____ Yes ____ No
Stool Consistency : ____ Hard ____ Soft
Urination Concerns: ____ Yes ____ No
Comments : _____

**Sleep**
Back Sleeping : ____ Yes ____ No
Duration: ____ <2 hrs ____ 2-4 hrs ____ >4 hrs
Location ____ co-sleep ____ crib ____ co-sleep & crib

**Tobacco Exposure:** ____ Yes ____ No
**Behavior concerns :** ____ Yes ____ No

Childcare _____