Office Use Only

VFC: [ ] V02 -- MDD
[ ] V03 -- No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

Newborn Questionnaire

Congratulations on the new addition to your family!

Office Use Only

WT: _____kg

WT: _____lb

HT: _____

OFC:_____

Temp: _____

Resp: _____

Pulse: _____

Oxygen: _____

Child's Name: _____ Birth Date: _____

Who is your child's primary care physician? _____

Do you have any concerns about your baby today? Such as: (please circle) Rash, Fever, Feeding concerns, Jaundice, Fussiness, Circumcision problems, Breathing problems, Other: _____

Any family history of bleeding disorders including Von Willebrands? Please list who and what: _____

Does your baby have any chronic medical problems? Yes / No. If yes, please explain. _____

Does your baby have a medication allergy? Yes / No. What medication/reaction? _____

Has your baby had any surgeries? Yes / No. If yes, please explain. _____

Has your baby been admitted to the hospital overnight? Yes / No. _____

Birth history/Delivery

Full term or premature (please circle) If premature, how many weeks early. _____

Vaginal or Cesarean (please circle) Head first or breech delivery (please circle)

Any complications? _____

Forceps or vacuum used (please circle)

Birth weight _____ Discharge weight _____ Length_____

Did your baby receive vitamin K at birth? Yes / No. Has your baby received the Hep B vaccine? Yes / No.

Nutrition/ Elimination

Breast feeding or Formula (please circle) When did milk come in? _____

Breast feeding, how often and how long? _____

Formula, which brand? _____ How many ounces and how often? _____

Do you have any questions or concerns you would like to discuss with the Certified Breast feeding Specialist? Yes/No

Is your baby taking any daily prescribed medications? Yes / No. If yes, please list: _____

Urine output/ # of wet diapers_____ Number of stools _____

Social

Who lives in the household with the baby (please list for all households, if more than one)? **Please specify relationship to child**

_____

Who is the primary caretaker in the home? _____

Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _____

Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _____

Any pets? Yes / No. If yes, which kind and how many?_____

Does anyone in the family smoke (inside or outside)? Yes / No. If yes, who? _____

Does anyone in the family have:

Asthma? Yes / No please circle: father / mother / brother / sister

Seasonal allergies? Yes / No please circle: father / mother / brother / sister

Any other family medical history:_____

This form completed by: _____ Relationship to Child: _____ Today's Date_____