*Office Use Only*

VFC: [ ] V02 -- MDD

[ ] V03 -- No Ins

[ ] V04 -- Native

[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

*Office Use Only*WT: \_\_\_\_\_\_\_kg \_\_\_\_\_\_\_lb

TEMP:\_\_\_\_\_\_\_ OFC:\_\_\_\_\_\_

Length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TECH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Newborn Questionnaire**

**Congratulations on the new addition to your family!**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition**

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

Urine output/ # of wet diapers\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of stools \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your baby taking any daily prescribed medications? Yes / No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your family have any pets? Yes / No. Please circle: dog / cat / other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Does anyone in the family smoke? 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

**This form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**