UW Medicine
UW NEIGHBORHOOD CLINICS

Newborn Well Child Visit

Baby's Name _____ Baby's Birth Date _____

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Perinatal Issues	**Yes**	**No**
Was your baby born on time?	( )	( )
Number of weeks pregnant on day of birth?	( )	( )
Birth weight?		
Was it a vaginal delivery?	( )	( )
Passed hearing screen?	( )	( )
Were pregnancy, labor & delivery complication-free (examples: pre-eclampsia, high blood pressure, diabetes, abnormal ultrasound, emergency delivery)?	( )	( )
Was your baby head-down at the time of delivery?	( )	( )
Was your baby discharged home without problems, such as jaundice?		
Was the pregnancy free of alcohol, smoking, and other drugs?	( )	( )

Review of Nutrition	**Yes**	**No**
Is your baby being breastfed exclusively?	( )	( )
Is your baby feeding well?	( )	( )
How often is your baby feeding?		
How long/How many ounces?		
Is your baby stooling comfortably?	( )	( )
Is your baby making 6 or more wet diapers per day?	( )	( )

Social Screening	**Yes**	**No**
Is the family doing well, with stable housing? If no, please list specific stress or problem:	( )	( )
Do you have family & friends in the area that can help out?	( )	( )
Are you feeling happy following the delivery?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Do you have a thermometer?	( )	( )
Do you have a crib/bassinette for your baby?	( )	( )
Is your baby in a car seat in the backseat facing backwards when in the car?	( )	( )

Developmental Screening	**Yes**	**No**
Does your baby like to gaze at your face?	( )	( )
Does your baby appear to respond to sounds?	( )	( )

Current concerns not listed above:

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