Newborn 0-7 Days Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

Birth History

1	What was your baby's weight at birth?			
2	Was your baby full term (was your pregnancy 38 or more weeks before delivery)?	YES	NO	
3	Did your baby pass the hearing test at birth?	YES	NO	Not sure
4	Did your baby get the Hepatitis B vaccine at birth?	YES	NO	Not sure
5	Did your baby have any problems after birth?	NO	YES	Not sure
6	Was your baby breech in the 3rd trimester or is there a family history of hip dysplasia or severe hip problems in children?	NO	YES	Not sure
7	Did your baby receive the vitamin K shot after birth?	YES	NO	Not sure

General Health

8	Do you have concerns about your baby?	NO	YES
9	Does your baby spit up or throw up a lot?	NO	YES
10	Do you have any concerns about skin color or rashes?	NO	YES
11	A rectal temperature of 100.4 or higher is a fever. Could you take your baby's rectal temperature if you needed to?	YES	NO

Feeding/Nutrition

12	Do you have any concerns about your baby's feedings?	NO	YES
13	Is your baby breastfeeding?	YES	NO
14	Is your baby taking breastmilk by the bottle?	YES	NO
15	Is your baby taking (drinking) formula?	YES	NO
	a. Which formula are you feeding your baby?		
16	Is your baby feeding at least 8 times a day?	YES	NO
17	Are you feeding your baby anything other than breastmilk or formula?	NO	YES

Elimination

18	How many poops has your baby had in the past 24 hours?	
	a. What color are your baby's poops?	
19	How many wet diapers (urine) has your baby had in the past 24 hours?	

Sleep

20	Do you have any questions or concerns about your baby's sleep habits?	NO	YES

Development

21	Does your baby turn and/or calm to your voice?	YES	NO
22	Do your child's eyes follow your face a little bit?	YES	NO
23	Does your child move the arms and legs well?	YES	NO
24	Does your child suck, swallow, and breathe easily when eating?	YES	NO

Social Stressors

25	If there are other children in the house, are they adjusting well to your newborn?	YES	NO	N/A
26	Are you having any family stress?	NO	YES	
27	Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
28	Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
29	Do you feel you receive the support you need?	YES	NO	
30	Do you ever feel angry or frustrated with your baby?	NO	YES	

Safety

31	Does your baby sleep on his/her back?	YES	NO
32	Where does your baby sleep?	Crib/Bassinet	Parents' Bed
33	Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
	a. Do you feel confident in securing your baby into your carseat?	YES	NO
34	Does anyone smoke or vape around your baby?	NO	YES
35	Do you have working smoke and carbon monoxide detectors in your home?	YES	NO

Tuberculosis

36 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
37 Has a family member ever had a positive TB skin test (PPD)?	NO	YES