

Office Use Only

VFC: [ ] MDD/DKC  
[ ] Native  
[ ] NO Insurance  
[ ] Not Eligible

INSURANCE Notes

# Newborn Questionnaire



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WT: \_\_\_\_\_ kg \_\_\_\_\_ lb

Congratulations on the new addition to your family!

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Do you have any concerns about your baby today? Yes / No. If yes, please explain. \_\_\_\_\_

### 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)

Breast feeding, how often and how long? \_\_\_\_\_

Formula, which brand? \_\_\_\_\_ How many ounces and how often? \_\_\_\_\_

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: \_\_\_\_\_