Surfside Pediatrics

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NEWBORN HEALTH QUESTIONNAIRE

Date:	
PATIENT INFORMATION	
Patient name:	Date of birth: Time of birth:
Who lives at the home of baby:	
Is there tobacco in the house: ☐ yes ☐ no	
DELIVERY INFORMATION	
Delivery Hospital:	or ☐ home birth ☐ birth center
Type of birth: ☐ induced ☐ spontaneous ☐ vaginal ☐ C-section ☐ Hep B administered ☐ Vitamin K administered	
Birth weight: ____lbs ____oz Gestational age:	Discharge date:
Delivery/Hospital Complications: ☐ none ☐ jaundice ☐ labs drawn	
MATERNAL INFORMATION	
Mom's age at delivery:	
Mom's health during pregnancy: ☐ gestational diabetes ☐ preeclampsia ☐ prenatal labs normal ☐ prenatal labs abnormal, please explain:	
Mom feeling sad?	
FEEDING INFORMATION	
☐ breast ☐ bottle ☐ both Name of formula using ________________________________ # of feeds per 24 hours _____________ # of pee/poop per 24 hours _____________ Concerns about feeding: ____ ____ ____ ____	
OTHER INFORMATION	
Other parental concerns/Questions: _____________________________________ ____ ____	