Health Information Update (Newborn)

INTAKE

Are you breastfeeding? ○ Yes ○ No

If yes, you breastfed baby for _______minutes, every ______ hours

Do you bottle feed your baby? ○ Yes ○ No

If yes, what type of formula do you give? ____

Your baby takes _______ ounces, every _________ hours.

Concerns: ____

OUTPUT

How many stools does your baby have per day? ______

What is the consistency? _________________

How often does your baby have a wet diaper per day? ______

If you have a boy, does your baby's urine stream seem straight? ○ Yes ○ No

SLEEP

How does your baby sleep? ○ On back ○ On side ○ On stomach

What does your baby sleep in? ○ Crib ○ Bassinette ○ Parent bed/co-sleeper ○ Swing/chair

Where does your baby sleep? ○ Parent's room ○ Own room ○ Room with sibling

What else is in the baby's sleeping area other than the crib/bassinette and mattress?_______________

SAFETY

Does your child ride in an infant car seat? ○ Yes ○ No

In the car seat, does your baby face: ○ Forward ○ Backward

CHILDCARE/SCHOOL

Who is with your baby most of the time? ○ Mom ○ Dad ○ Babysitter ○ Family member

OTHER

List any medications your child takes:

____

Do you need any medication refills? ____

Concerns? ____