Newborns Questionnaire

Name:_____________________________ Date:______________

Height: _____ Weight: _______ HC: _____ Temp: _____

Gestational age? ______________

C-Section or Vaginal? _______________

Was baby circumcised? Yes/No If so when? _______________

Were there any complications? Yes/No

Were you GBS + ? Yes/No

NICU Stay? Yes/No If so how many days? _________

What was the baby's birth weight? _____________

What was baby length? _____________

When was baby discharged? _______________

Did baby pass his/her hearing screening? Yes/No, Both Eras? Yes/No

What was mom blood type? ________________

What was baby's blood type? ________________

Did mom take prenatal vitamins? Yes/No

Did baby receive Hep B @ the hospital? Yes/No, if so when? ____________________

Was baby's 1 feeding breast milk or formula? ____________________

If formula which one and how many ounces? _____________________

What is the longest stretch of hours your baby sleeps? ____________________

How many wet diapers per day? ________

How many stool diapers per day? _________

Are there any siblings? Yes/No, If so how many? ____________

Are there any pets in the household? _______________

Does Anyone in the Family/ household smoke? Yes/No