Newborn – Well Child Care Name:_____

Please circle the best answer as it pertains to your child and fill in the blanks.

Delivery

Were there problems with the delivery?_____
Did your baby receive the Hepatitis B vaccine? ____ If so, what was the date?_____

Feeding

How is the baby fed? (circle one)	Breast Fed	Formula Fed
If Formula Fed, what is the name of the formula?_____		
If breastfeeding, is the child on a vitamin D supplement (e.g. trivisol)?	Yes	No
How often does the baby feed?_____		
Mother able to tell when baby is hungry	Yes	No
Can you hear the baby swallow	Yes	No
How many urine soaked diapers does the baby have every 24 hours? _____		
How many bowel movements does the baby have every 24 hours? _____		
What do the stools look like (soft, seedy, loose)? _____		

Household

Is the mother recovering well from the delivery? _____
Where does the baby sleep and is it on her/his back?_____
Who lives in the home (e.g. Father, mother, brother, etc.)? _____

Safety

Is the car seat in the back seat and rear facing?	Yes	No
Is your child exposed to tobacco smoke?	Yes	No
Are there any improperly stored firearms in the home?	Yes	No
Is the hot water temperature set low enough to prevent accidental burns?	Yes	No
Are there working smoke detectors in the home?	Yes	No

Miscellaneous

Who cares for the child at home most of the time? _____
Who else helps you care for your baby? _____

Do you have a rectal thermometer for the baby?	Yes	No
Any concerns about your child?	Yes	No

If yes, what are they?

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building bult before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- If born before 1/1/2015, lives in a 2004 "at-risk" zip code?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead.
- Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Was your child born in, or lived more than a year in a country other than the U.S.?
- Has your child been exposed to anyone with either active or a history of Tuberculosis disease?
- Is your child living in a house hold with anyone who is HIV Positive?
- Is your child part of a migrant worker family?

Weight _____

Height _____

Head Circumference _____

Blood Pressure _____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: