Newborn: 0-7 Days Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have concerns about your baby?	NO	YES
2	Has your baby been sick since leaving the hospital?	NO	YES
3	Does your baby spit up or throw up a lot?	NO	YES
4	Does your baby cry a lot? (more than 3 hours/day)?	NO	YES
5	Does your baby have a stuffy nose that makes it hard to feed?	NO	YES
6	Do you have any concerns about skin color or rashes?	NO	YES
7	Did you know that a rectal temperature of 100.4 or higher is a fever?	YES	NO
8	Could you take your baby's rectal temperature if you need to?	YES	NO

Feeding/Nutrition

9	Is your baby breastfeeding?	YES, Very well	Not Well. I have questions/concerns
10	Is your baby taking breastmilk by the bottle?	YES, Very well	Not Well. I have questions/concerns
11	Is your baby taking formula?	YES, Very well	Not Well. I have questions/concerns
a	Which formula are you feeding your baby?		
12	Is your baby feeding at least 8 times a day?	YES, Very well	Not Well. I have questions/concerns
a	Do you have concerns about your baby's feeding?		
13	Are you feeding your baby anything other than breastmilk or formula?	NO	YES

Elimination

14 Does your baby have any problems with bowel movements (going poop)?	NO	YES
a What color are your baby's poops?		
15 Does your baby urinate (pee) at least four/five times each day?	YES	NO

Sleep

16 Do you have any questions or concerns about your baby's sleep habits?	NO	YES

Social Stressors

17 Has either parent been feeling down, depressed, or hopeless?	NO	YES	
18 Has either parent had little interest or pleasure in doing things they used to enjoy?	NO	YES	
19 If there are other children in the house, are they adjusting well to your newborn?	YES	NO	N/A
20 Are you having any family stress?	NO	YES	
21 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
22 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
23 Do you feel that you receive the support you need?	YES	NO	
24 Do you Ever feel angry or frustrated with your baby?	NO	YES	

Development

25 Does your baby turn and/or calm to your voice?	YES	NO
26 Do your baby's eyes follow your face a little bit?	YES	NO
27 Does your baby move his/her arms and legs well?	YES	NO
28 Does your baby suck, swallow, and breathe easily when eating?	YES	NO

Safety

29 Does your baby sleep on his/her back?	YES	NO
30 Where does your baby sleep?	Crib/Bassinet	Parents' bed
31 Does baby ride in a rear-facing safety seat, in the back seat?	YES	NO
a Do you feel confident in securing your baby into your carseat?	YES	NO
32 Does anyone smoke or vape around your baby?	NO	YES
33 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO

Tuberculosis

34 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
35 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
36 Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe?	NO	YES

Birth History

37 What was your baby's weight at birth?			
38 Was your baby full term (was your pregnancy 38 or more weeks before delivery)?	YES	NO	
39 Did your baby pass the hearing test at birth?	YES	NO	not sure
40 Did your baby get the Hepatitis B vaccine at birth?	YES	NO	not sure
41 Did your baby have any problems in the nursery?	NO	YES	not sure
42 Was your baby breech?	NO	YES	not sure