FIRST WEEK

Name of Patient _____ Date of Birth _____

Birth History:	Date: «VisitApptDate»__
☐ Was your baby born full term? _____weeks.	☐ Vaginal or C-section?
☐ What was the birth weight? _____	☐ APGAR scores: 1 min ____, 5 min ___
☐ Were there complications during pregnancy, delivery or after birth?	_____ _____
Do you have any concerns you would like to discuss?	_____ _____

Review of Systems		
How are **YOU** feeling: **Please mark any concern that you have**		
☐ Your Health	☐ Unwanted Advice	☐ Family Stress
☐ Feeling Sad	☐ Starting Daily Routine	
Getting Used to Your **BABY**: **Please mark topics you would like to discuss today**		
☐ How are you doing with your baby	☐ Calming your baby	☐ Crib Safety
☐ Where your baby sleeps	☐ How your baby sleeps	☐ Placing baby to sleep
☐ Gaining Weight	☐ How your baby shows if he/she is hungry/full	☐ Drinking enough
☐ Jaundice (Yellow Skin)	☐ Burping	☐ Breast / Formula Feeding
☐ Car Seat Safety	☐ Cigarette Smoke	☐ Water heater
☐ When to call the doctor's office	☐ Your baby's temperature	☐ Not getting sick
☐ Hand washing	☐ Emergency situation	☐ Leaving the house
☐ Skin Care	☐ Sunburns	

Personal/Social History:			
Are you Concerned about your baby's			
YES	**NO**	**YES**	**NO**
☐	☐ Feeding?	☐	☐ Excessive spitting or vomiting?
☐	☐ Bowel movements?	☐	☐ Straining or crying with void?
☐	☐ Nasal stuffiness?	☐	☐ Skin color or skin rashes?
☐	☐ Excessive crying?	☐	☐ Body movements, especially extremities?
☐	☐ Lack of response to your face or blink at light?	☐	☐ Lack of response to a loud noise?
☐	☐ Sleep habits?	☐	☐ Do you know infant CPR?
☐	☐ Does he/she sleep on back?	☐	☐ Do they ride in a rear-facing safety seat?
☐	☐ Live in a smoke-free home		

Parent Signature:_____ Date: _____«VisitApptDate»___

Name of Patient _____ Date of Birth _____

Social History:

1. Lives at home with:	Mom	Dad	Both Parent	Other
2. Smokers in house?	Yes	No	Who smokes?	_____
3. Are there any Firearms in the house?	Yes	No		
4. Do you have a Swimming Pool?	Yes	No		
5. Home smoke detector use?	Yes	No		
6. Pets	Yes	No		

Parent Signature:_____ Date: _____«VisitApptDate»___