Kids Way Clinic

Newborn Information Sheet

Please fill out COMPLETELY

Child's Name: ______________________________
Date and time of birth: ____________________ Date of discharge from hospital: __________________
Who is filling this form out? ____

PREGNANCY HISTORY:
Was pregnancy planned? __________________
Which trimester was prenatal care started? ___________________________________
How many weeks along was mom at delivery? __________________
Any health problems during pregnancy? (Abnormal ultrasounds, abnormal screening, infections, group B strep positive, high blood pressure, diabetes, etc)

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Medications, supplements taken during pregnancy:

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Was there any substance use/alcohol/ tobacco use during pregnancy? __________________
Are there any smokers in the home?______________________ If so, who? ______________________

DELIVERY HISTORY:
Any complications during delivery?

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Was the birth Vaginal, Assisted (vacuum, forceps), or C-section?____________________________
If applicable; reason for C-Section:____

Any problems with the baby after delivery? (not breathing, not maintaining body temperature, low glucose, fever, needing antibiotics,etc)

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Where was the child born at:

Hospital name: _____________________________ City:____________________________
Birth Weight:__________________ Birth Length:_________________

Is the baby bottle fed or breast fed? ____
How much does the baby feed and how often?_______________________________________
If applicable; brand of formula:____
Number of wet diapers per day:____________________
Number of poopy diapers per day:__________________

Maternal blood type:__________________ Baby's blood type:___________________

Did the baby receive the Hep B vaccine?______________________
Was the newborn screening test performed?__________________
Did the baby pass the newborn hearing screen? _____________