

# 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.

## Birth History

1	What was your baby's weight at birth?			
2	Was your baby full term (was your pregnancy 38 or more weeks before delivery)?	YES	NO	
3	Did your baby pass the hearing test at birth?	YES	NO	Not sure
4	Did your baby get the Hepatitis B vaccine at birth?	YES	NO	Not sure
5	Did your baby have any problems after birth?	NO	YES	Not sure
6	Was your baby breech in the 3rd trimester or is there a family history of hip dysplasia or severe hip problems in children?	NO	YES	Not sure
7	Did your baby receive the vitamin K shot after birth?	YES	NO	Not sure

## General Health

8	Do you have concerns about your baby?	NO	YES
9	Does your baby spit up or throw up a lot?	NO	YES
10	Do you have any concerns about skin color or rashes?	NO	YES
11	A rectal temperature of 100.4 or higher is a fever. Could you take your baby's rectal temperature if you needed to?	YES	NO

## Feeding/Nutrition

12	Do you have any concerns about your baby's feedings?	NO	YES
13	Is your baby drinking breastmilk?	YES	NO
14	Is your baby taking (drinking) formula?	YES	NO
	a. Which formula are you feeding your baby?		
15	Is your baby feeding at least 8 times a day?	YES	NO
16	Are you feeding your baby anything other than breastmilk or formula?	NO	YES

## Elimination

17 How many poops has your baby had in the past 24 hours?	
a. What color are your baby's poops?	
18 How many wet diapers (urine) has your baby had in the past 24 hours?	

## Sleep

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

20 Does your baby turn and/or calm to your voice?	YES	NO
21 Do your child's eyes follow your face a little bit?	YES	NO
22 Does your child move the arms and legs well?	YES	NO
23 Does your child suck, swallow, and breathe easily when eating?	YES	NO

## Social Stressors

24 If there are other children in the house, are they adjusting well to your newborn?	YES	NO	Doesn't apply
25 Are you having any family stress?	NO	YES	
26 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
27 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
28 Do you feel you receive the support you need?	YES	NO	
29 Do you ever feel angry or frustrated with your baby?	NO	YES	

## Safety

30 Does your baby sleep on his/her back?	YES	NO
31 Where does your baby sleep?	Crib/Bassinet	Other
32 Does your 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
33 Does anyone smoke or vape around your baby?	NO	YES
34 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO

Tuberculosis

35 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
36 Has a family member ever had a positive TB skin test (PPD)?	NO	YES