



ABC Pediatrics

Newborn Pre-visit Questionnaire

Patient Name _____

Date _____

Sponge bathing every _____ day(s)

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Formula: _____ Ounces per feeding? _____ Every how many hours? _____

of stools Daily _____ # of voids Daily _____ # of hours sleeping at ONE time _____

Umbilical cord still attached? _____ Comments _____

Circumcision concerns (if applicable)? _____

Feeding Concerns:

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things? _____

Have there been any major changes in your family recently other than your baby's birth? _____

Developmental Milestones (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Responds to sounds | <input type="checkbox"/> Vocalizes Coos |
| <input type="checkbox"/> Blinks in reaction to light | <input type="checkbox"/> Follows Objects to midline |

Any other questions or concerns you would like to discuss?

Weight _____ Temp _____ Height _____ Head Circumference _____