

Newborn Health Visit / Early Head Start

DATE: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: Male / Female

Parent's Name: \_\_\_\_\_

Baby's HCP: \_\_\_\_\_

Mother's HCP: \_\_\_\_\_

BIRTH WEIGHT	LENGTH@BIRTH	BABY	MOTHER
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- |                          |                      |                          |      |
|--------------------------|----------------------|--------------------------|------|
| <input type="checkbox"/> | active, good color   | <input type="checkbox"/> | Good |
| <input type="checkbox"/> | sleeping, good color | <input type="checkbox"/> | OK   |
| <input type="checkbox"/> | jaundiced, lethargic | <input type="checkbox"/> | Fair |
| <input type="checkbox"/> | other                | <input type="checkbox"/> | Poor |

Interval History:

Gest. Age at delivery: \_\_\_\_\_

APGAR score: 1 min. \_\_\_\_\_ 5 min. \_\_\_\_\_

Medications:  
\_\_\_\_\_  
\_\_\_\_\_

Injury or Illness:  
\_\_\_\_\_  
\_\_\_\_\_

Special Health Care Needs:  
\_\_\_\_\_  
\_\_\_\_\_

Visits to health care providers or facilities:  
\_\_\_\_\_  
\_\_\_\_\_

Change/Stressors in family or home:  
\_\_\_\_\_  
\_\_\_\_\_

Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Questions for Parent:

How are you feeling? \_\_\_\_\_  
\_\_\_\_\_

How did the delivery go? \_\_\_\_\_  
\_\_\_\_\_

Delivery Location:  
 Hospital  BC  Home  Other

Type of Delivery:  
 Vaginal  Cesarean Section

Length of baby's hospital stay:  
 Routine  non-routine (< one week)  
 One week to one month  
 Over one month

Reason for non-routine hospital stay:  
\_\_\_\_\_  
\_\_\_\_\_

What do you other children think about the new baby?  
\_\_\_\_\_  
\_\_\_\_\_

What are your questions about feeding the baby?  
\_\_\_\_\_  
\_\_\_\_\_

What questions or concerns would you like to discuss today?  
\_\_\_\_\_  
\_\_\_\_\_

**Anticipatory Guidance Healthy Habits**

- \_\_\_\_\_ Car Seat
- \_\_\_\_\_ Crib Safety
- \_\_\_\_\_ Sleep on back
- \_\_\_\_\_ Water Temperature <120
- \_\_\_\_\_ Keep hand on baby
- \_\_\_\_\_ Smoke-Free environment
- \_\_\_\_\_ Hot liquids, cigarettes
- \_\_\_\_\_ Signs of illness
- \_\_\_\_\_ Emergency procedures

**Nutrition**

- \_\_\_\_\_ Successful breastfeeding practices  
(Positioning, latching on, feeding on cue)
- \_\_\_\_\_ 6-8 wet diapers per day
- \_\_\_\_\_ Maternal care (rest, nipple care, eating properly, follow up support)
- \_\_\_\_\_ Formula (preparation, equipment, semi-sitting position)
- \_\_\_\_\_ No bottle in bed or microwave

**Infant Care**

- \_\_\_\_\_ Cord
- \_\_\_\_\_ Intact penis or circumcision care
- \_\_\_\_\_ Vaginal discharge, bleeding
- \_\_\_\_\_ Skin, nails
- \_\_\_\_\_ Crying
- \_\_\_\_\_ Sneezing, hiccups
- \_\_\_\_\_ Burping, spitting up
- \_\_\_\_\_ Thumb sucking, pacifiers
- \_\_\_\_\_ Sleep patterns, arrangements
- \_\_\_\_\_ Meconium to transitional stools
- \_\_\_\_\_ Thermometer use
- \_\_\_\_\_ Layers of clothing

**Parent/Infant Interaction**

- \_\_\_\_\_ Baby's temperament
- \_\_\_\_\_ Console baby
- \_\_\_\_\_ Hold, cuddle, rock
- \_\_\_\_\_ Talk, sing

**Family Relationships**

- \_\_\_\_\_ Partner Involvement
- \_\_\_\_\_ Rest, fatigue, depression
- \_\_\_\_\_ Support from family/friends
- \_\_\_\_\_ Siblings' reactions: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Other Needs:**

- \_\_\_\_\_ Offer materials for review at home on child.  
(Safety, childproofing home, breastfeeding)
- \_\_\_\_\_ Suggest resources to help with breastfeeding.
- \_\_\_\_\_ Provide information about parenting classes or support groups
- \_\_\_\_\_ Suggest community resources.
- \_\_\_\_\_ Discuss how to access health care.

**Referrals**

- \_\_\_\_\_ Health insurance/Medicaid
- \_\_\_\_\_ SSI
- \_\_\_\_\_ Part C
- \_\_\_\_\_ WIC
- \_\_\_\_\_ Food Stamps
- \_\_\_\_\_ Social Services
- \_\_\_\_\_ Housing
- \_\_\_\_\_ Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Mother's Signature: \_\_\_\_\_

Father's Signature: \_\_\_\_\_

EHS Health Staff Signature: \_\_\_\_\_