Physicians at Sugar Creek
An Affiliate of MEMORIAL HERMANN

14023 Southwest Freeway
Sugar Land, TX 77479
218.325.4100

Newborn Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child's health that you would like to discuss today?

_____

_____

_____

What is your child's health Status? **Good Fair Poor**

Has your child been to the emergency room in the past 12 months: **Yes No**

If yes, list why: _____

Has your child been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: _____

Has your child ever had any reactions to vaccines / immunizations: **Yes No**

HOME and FAMILY

Who does the child live with: _____ How many brothers and sisters does he/she have? _____

What do you live in? _____ How many bedrooms are in your home? _____

Does your child share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your child's Father Involved in his/her care? **Yes No**

How is your child's relationship with his brothers and/or sisters? **Good Fair Poor N/A, only child**

What type of discipline is used in the home: **Verbal Time-out Spanking Other: _____**

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _____

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GENERAL HEALTH

How does your child feed? **Breast feeding** **Pump then bottle feed** **Formula feeding**

How well does he/she breastfeed? **Well** **Poorly**

How long does he/she breastfeed per side? _____

If using formula, what type ? _____

If using formula, how much milk in each bottle? **1 oz** **2 oz** **3 oz** **4 oz**

How often does he/she feed? Every: **hourly** **2 hours** **3 hours** **4 hours** **5 hours**

How often does your child have a bowel movement? _____

How often does your child urinate (have a wet diaper)? _____

How does your child sleep? **Supine (back)** **Side** **Prone (stomach)** **Crib** **Bassinet**

How would you describe your child's temperament? **Easy** **Colicky** **Demanding**

Cries when hungry or with needs **Fussy all the time** **Fussy at night** **Fussy but consolable**

Do you have any concerns about:

Your child's development? **Yes** **No**

Your child's behavior? **Yes** **No**

HEARING

Does your child:

Calms to a familiar, friendly voice **Yes** **No**

Wakes up when you speak or make noise nearby **Yes** **No**

VISION

Do you have any concerns about how your child sees **Yes** **No**

Do you child's eyes appear unusual or seem to cross, drift, or be lazy? **Yes** **No**

Do your child's eyelids droop or does one eyelid tend to close? **Yes** **No**

Have your child's eyes ever been injured? **Yes** **No**

Check off each task that your child is able to do:

- ☐ Raise body when lying on stomach
- ☐ Moves arms and legs equally
- ☐ Focuses briefly at faces or objects
- ☐ Cries for communication
- ☐ Responds to stimuli
- ☐ Looks at your face

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GENERAL SAFETY

Does your child always use a car seat? **Yes No**

Is your home childproofed? **Yes No**

Do you have these things in your home:

- Smoke detector **Yes No**
- Carbon monoxide detector **Yes No**
- Fire extinguisher **Yes No**