Cornerstone Well Child Form – Newborn 0-1week

Name: _____ Date of Birth: _____

Parents, please take a few minutes to answer the following questions regarding your new baby…

Maternal and Delivery

Mother's age _____ Total # of pregnancies _____

Delivery ☐ Vaginal ☐ Cesarean Section ☐ Forceps/Vacuum

Delivery Complications ☐ None ☐ Yes: _____ _____

Maternal Complications ☐ None ☐ Yes: _____ _____

Newborn Course

Birth Length _____ Birth Weight _____ Discharge Weight _____

☐ Hepatitis B vaccine given in hospital

Hospital Stay (Infant)

☐ Normal ☐ Complications _____ _____

Nutrition

Breastfed Babies

_____ Minutes/feeding

Breast fed every _____ hours

Bottle Fed Babies

_____ Ounces/feeding

Bottle fed every _____ hours

Dietary Supplements

☐ None ☐ Other _____

Caregiver Concerns

Nutrition Concerns ☐ None ☐ Yes: _____

Elimination Concerns ☐ None ☐ Yes: _____

Sleep Concerns ☐ None ☐ Yes: _____

Developmental Milestones

☐ Moves arms & legs equally ☐ Fixes on faces

☐ Lifts head ☐ Startles with sound

Other Development Concerns: ☐ None ☐ Yes: _____

For Office Use Only

Weight: _____ Pulse: _____ HC: _____

Length: _____ Temp: _____