

Birth through 2 week Questionnaire

Patient's Name: _____

Pregnancy History:

Was your pregnancy Full Term Premature (# of weeks _____)

Were there any abnormal findings on prenatal ultrasounds? _____

Were there any complications during the pregnancy? _____

Did you have Group B Strep (GBS), Hepatitis B, or Tuberculosis (TB) during the pregnancy? _____

Birth History:

Was your baby born at Prince William Heathcote Fair Oaks Fairfax
 Reston Other _____

Was your baby born via C-Section or vaginal birth

Did your baby get the Hepatitis B vaccine? _____ Date: _____

Did mom get the Tdap vaccine? _____ Has dad had Tdap? _____

Is there a family history of congenital hip dislocation or was your baby a breech presentation?..... Yes No

Did your baby receive phototherapy? Yes No

Did your baby pass the hearing screen? Yes No

Personal/Social History

Are you concerned about your baby's...

1. Feedings? Yes No
 Breast Formula

2. Excessive spitting, vomiting, or problems latching for breastfed infants? Yes No

3. Bowel movements? Yes No

4. Nasal stuffiness, congestion, or wheezing? Yes No

5. Skin color or rashes? Yes No

6. Crying more than 3 hours per day? Yes No

7. Sleep habits? Yes No

8. Growth? Yes No

9. Development? Yes No

Answer the following:

10. Is your child exposed to tobacco smoke? Yes No

11. Have you been depressed or crying lately? Yes No

12. Are your infant's bowel movements white or gray or blood streaked? Yes No

13. Does your baby co-sleep with you in bed? Yes No

14. Have you traveled out of the country or do you plan to travel to another country in the next year, OTHER THAN: Western Europe, Canada, Australia, or New Zealand? ... Yes No

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Does your child...

- 15. Look at your face or the ceiling fan or lights? Yes No
- 16. Startle at loud noises? Yes No
- 17. Lift his/her head off your shoulder when held upright?..... Yes No
- 18. Move all extremities equally well?..... Yes No

Answer the following:

- 19. Do you have any help with the baby? Yes No
- 20. Does your child ride in a rear-facing infant car seat? Yes No
- 21. Do you know infant CPR? Yes No
- 22. Does your baby sleep with a pacifier? Yes No
- 23. Do you put your baby to bed on his/her back? Yes No
- 24. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season?..... Yes No

Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

- 1. Are you giving vitamin D? Yes No
- 2. Breast feeding mothers, are you taking a multivitamin with iron? Yes No
- 3. Are you having any problems nursing? Yes No
- 4. Do you need help from our lactation specialists?..... Yes No
- 5. Do you need help with preparations to return to work? Yes No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

- 1. Your infant is less than 12 months old with chronic lung or congenital heart disease ... Yes No
- 2. Your infant was a premie of 28 weeks or less and is less than 12 months old Yes No
- 3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months Yes No
- 4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder Yes No
- 5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise Yes No
- 6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant Yes No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? Yes No
