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

Birth through 2 week Questionnaire

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 preemie 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

_____

_____

_____

_____