**PEDIATRIC HEALTH**
**ASSESSMENT HEALTH**
**First week 2-5 days**

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CHILD'S NAME: ______________________________ DATE: ______________ AGE: ______________

PRESENT CONCERNS/PROBLEMS: ______________________________________________

______________________________________________________________________

______________________________________________________________________

ACCOMPANIED BY: ________________________ RELATIONSHIP: ________________________

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**NEWBORN HISTORY:**

Mom's blood type: ______ Baby's blood type: _______ Birth Weight: ______________ How early was baby: __________ weeks

Were there any problems with the pregnancy? ______________________________________________

Was mom on any medications during pregnancy?______________________________________________

Were there any concerns/problems when the baby was born? ______________________________________________

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**SOCIAL/FAMILY HISTORY**

Adjustment to new child______________________________________________

Reaction of siblings to new child______________________________________________

Work Plans for Mom/ child care plans ______________________________________________

Who lives in household? ______________________________________________

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**NUTRITION**

Feeding: circle Bottle or Breast

Formula Type ________________________ Breast fed: How often - every ______hours or number feeds ______per day

Ounces per Feed________________________ Total minutes of breast feeding per feed________________________

Hours between feed_____________ Feedings/24 hours__________

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URINE: Number of wet diapers per day_______________ STOOL: Number of bowel movements per day________________

Does baby sleep in own bassinette? ☐ Yes ☐ No Sleep Position: ______________________________________________

Behavior: ______________________________________________

Toxic exposure: Lead ☐ Yes ☐ No Smokers in household ☐ Yes ☐ No Exposure to TB: ☐ Yes ☐ No
Smoke Detector in house at home? ☐ Yes ☐ No Car seat always used? ☐ Yes ☐ No

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DEVELOPMENT

Motor
- ☐ Raises head slightly in prone position

Sensory
- ☐ Blinks in reaction to bright light
- ☐ Follows object to midline
- ☐ Responds to sound