PEDIATRIC HEALTH
ASSESSMENT HEALTH
First week 2-5 days

CHILD'S NAME: _____DATE: _____ AGE: _____

PRESENT CONCERNS/PROBLEMS: _____

_____

_____

ACCOMPANIED BY: _____RELATIONSHIP: _____

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? _____

SOCIAL/FAMILY HISTORY

FAMILY SITUATION

Adjustment to new child_____

Reaction of siblings to new child_____

Work Plans for Mom/ child care plans _____

Who lives in household? _____

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_____

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

Development

Motor
□ Raises head slightly in prone position

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