Kīpuka o ke Ola

Native Hawaiian Rural Health Clinic
Physical Address: 64-1035 Māmalahoa Hwy, Suite F, Kamuela, HI 96743
Mailing Address: PO Box 818, Kamuela, HI 96743
Office Phone: 808-885-5900 FAX: 808-885-6900

Well Baby Check: New Born Visit Questionnaire

Today's date: ________Name: ______________________________

□ Male □ Female Date of Birth: __________ Hospital Delivered at: ______________________

Interval History:

1. Number of weeks pregnant on day of birth?			
2. Were there any pregnancy, labor & delivery complication (examples: pre-eclampsia, high blood pressure, diabetes, abnormal ultrasound, emergency delivery, etc.)?	No	Yes – Please explain:	
3. Was the pregnancy free of alcohol, smoking, and other drugs?	Yes	No – Please explain:	
3. Has your baby had any illnesses, ER or Urgent Care visits since hospital discharge?	No	Yes – Please explain	
4. Did your baby pass the hearing test done in the hospital?	Yes	No	Unsure
5. Did your baby have a Newborn Screen done in the hospital?	Yes	No	Unsure

1. Please list any medications or supplements your baby is taking: ______________________
2. Please list any major family medical issues: ______________________

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3. Please list any known Allergies: ______________________

Staying Healthy/Safety/Dental Health/Tobacco Exposure:

1. Does your home have a working smoke detector?	Yes	No	Unsure
2. Have you turned your water temperature down to less than 120 degrees)?	Yes	No	Unsure
3. Do you always place your baby in a rear-facing car seat in the back seat?	Yes	No	
4. Does anyone smoke in or outside of the house?	Yes	No	
5. Do you always put your baby to sleep on her/his back?	Yes	No	
6. Baby sleeps…	With me	In a crib	Other- Please explain:
7. Do you have a thermometer?	Yes	No	

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Parents and Family:

Who lives at home with your child?

Name	Age	Relationship to your child	Occupation	Highest Education Level

In the past year have there been any changes in your family? (check all that apply)

- □ Marriage
- □ Separation
- □ Divorce
- □ Loss of job
- □ Move to new neighborhood
- □ Change to new school
- □ Serious illness
- □ Death
- □ Other changes/stresses (Please Explain): ____________________

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2. Do you have family & friends to help out?	Yes		No	
3. Are you feeling down, depressed, irritable, or hopeless?	Not at All	Several Days	More than half the days	Nearly every day
4. Are you having little interest or pleasure in doing things?	Not at All	Several Days	More than half the days	Nearly every day

Nutrition/Physical Activity:

1. What was your baby's birth weight?	_____ lbs & _____ oz	
2. How many feedings in 24 hrs?		
2a. For Breastfeeding: How many minutes per side per feeding?		
2b. For formula/bottle feeding: How many ounces per feeding?		
2c. If you are giving formula, what brand are you using?		
3. Do you have any concerns about your baby's feeding/weight?	NO	Yes- Please explain:

Elimination:

Does your baby have at least 6+ wet diapers in 24 hours?	Yes	No – How many?
Does your baby have soft, yellow bowel movements?	Yes	No - Please Explain:
Is your baby stooling comfortably?	Yes	No - Please Explain:

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Development:

1. Does your baby regard your face (starting to focus with his/her eyes)?	Yes	No
2. Does your baby respond to voices or sounds?	Yes	No
3. Does your baby move both arms and legs equally?	Yes	No
4. Does your baby responds to your attempts of soothing them?	Yes	No
5. Do you have any concerns about how your baby sees or hears?	Yes	No

4. Do you have any concerns about your child's development, or any other concern you would like to discuss with your Provider: ______________________________

BIOLOGICAL FAMILY HISTORY

Have any FAMILY members had the following? If yes, please explain:

Childhood hearing loss	□ Yes	□ No	□ Don't know	
Nasal allergies	□ Yes	□ No	□ Don't know	
Asthma	□ Yes	□ No	□ Don't know	
Tuberculosis	□ Yes	□ No	□ Don't know	
Anemia	□ Yes	□ No	□ Don't know	
Bleeding disorder	□ Yes	□ No	□ Don't know	
Dental decay	□ Yes	□ No	□ Don't know	
Cancer (before 55 years old)	□ Yes	□ No	□ Don't know	
Liver disease	□ Yes	□ No	□ Don't know	
Kidney disease	□ Yes	□ No	□ Don't know	
Diabetes (before 55 years old)	□ Yes	□ No	□ Don't know	
Obesity	□ Yes	□ No	□ Don't know	
Alcohol abuse	□ Yes	□ No	□ Don't know	
Drug abuse	□ Yes	□ No	□ Don't know	
Mental illness/depression	□ Yes	□ No	□ Don't know	
Developmental disability	□ Yes	□ No	□ Don't know	
Immune problems, HIV, or AIDS	□ Yes	□ No	□ Don't know	
Tobacco use	□ Yes	□ No	□ Don't know	

Additional family history: ______________________________

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