Patient's Name: ________________________________
Date: ______________________ DOB: ______________

NEWBORN INTERVAL HISTORY FORM

(0-60 Days)

1. How are you (mom) feeling?

2. How are you managing the care of your baby? Who is available to help you at home?

3. How are your other children doing?

4. Do you hold and/or rock the baby to sleep?

5. What position do you put the baby in when sleeping?

6. When your infant becomes fussy, what do you do?

7. Is your baby breast-fed or formula-fed?

If breast-fed:	**If formula-fed:**
Frequency of Feedings: Day ____________	Frequency of Feedings: Day ______________
Night ______________	Night ______________
Average length of feeding____________________	Type of formula __________________________
Baby removes self from breast? ❑ Yes ❑ No	Amount at each feeding __________________
Swallowing heard ❑ Yes ❑ No	Baby appears satisfied ❑ Yes ❑ No
Nursing both breasts ❑ Yes ❑ No	Other Intake ❑ Water
Baby appears satisfied ❑ Yes ❑ No	❑ Baby Food/cereal
Other Intake	
❑ Water ❑ Other:	
❑ Baby Food/cereal	
❑ Other:____________________	

8. Do you have well water or city water?

9. Describe your living conditions.

10. Do you or anyone in the house smoke?

11. Do you or anyone in your house use alcohol or drugs?

12. Are there firearms in your home?

13. Do you have any family stressors?

14. What do you do when things seem to be too much?

15. What are each parent's plans about working outside the home and what are plans for care of the baby?

Do you have the following items in your home?

- ❑ Yes ❑ No Smoke Detectors
- ❑ Yes ❑ No Crib with slats less than 2 3/8th inces apart
- ❑ Yes ❑ No Crib Bumper
- ❑ Yes ❑ No Pets
- ❑ Yes ❑ No Car Seat
- ❑ Yes ❑ No Electric Plug Covers
- ❑ Yes ❑ No Thermometer

Do you know how to?

- ❑ Yes ❑ No Bathe your infant
- ❑ Yes ❑ No Care for the umbilical cord
- ❑ Yes ❑ No Care for your son's circumcision
- ❑ Yes ❑ No Take your baby's temperature
- ❑ Yes ❑ No Properly belt your car seat
- ❑ Yes ❑ No Properly prepare and store your baby's formula and bottles

Completed by: ___________________________________

Date: ____

MD Reviewed: ___________________________________
Signature/Date