

3-5 Day Newborn Hospital Follow-up

Hirsch Holistic Family Medicine
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Patient name: _____ Date _____ Age _____
Accompanied by: _____ Birthdate _____

PARENT SECTION: Please check yes or no and fill in the blanks.

BIRTH HISTORY

No Yes Health problems affecting children run in my family _____
My due date was _____
My baby's birth weight was _____
He/she was born by: c-section / vaginal delivery

No Yes Were there any complications with the pregnancy or delivery?
If yes, what? _____

GENERAL ISSUES

Yes No Overall, I feel confident that my baby is doing well

No Yes I am having some baby blues

Yes No I have enough help with the baby
Who lives with you and the baby? _____

No Yes My baby seems fussier than the average baby

FEEDING/SLEEPING

No Yes I have questions about my baby's feeding
Breast fed: _____ min every _____ hrs.
Bottle fed: _____ formula _____ oz every _____ hrs

No Yes My baby has a problem with spitting up

No Yes I have questions about my baby's sleep habits
Longest sleep period: Daytime _____ Nighttime _____
Where does your baby sleep? _____

No Yes Is your baby's skin looking yellow?

VOIDING/STOOLING

Yes No My baby pees and poops normally
Per day: wet diapers _____ stool diapers _____

PREVENTION

No Yes My baby lives with someone who smokes cigarettes

Yes No I always keep my baby in the car seat when driving

Yes No My baby sleeps only on his/her side or back

Yes No I know the signs of illness in a newborn

Yes No Are there any other issues you want to discuss today?

DISCUSSION TOPICS

Perinatal risk factors
GBS
Breech - hips

General questions
Postpartum depression
Exhaustion
Parenting support
Sibling, partner adjustment

Continue breastfeeding
Feed every 2-4 hours
Normal vs. pathologic reflux
Supine sleep position
Safe sleep environment

Normal variation

Smoking cessation
No exceptions with car seat
SIDS prevention
Call for fever over 100.4

PHYSICAL EXAM: (all items examined unless crossed out. Abnormalities circled and commented on)

Weight: _____ kg (Birth Weight)

T: _____

P: _____

RR: _____

General Appearance:	alert, no apparent distress	_____
Skin:	no lesions, no jaundice	_____
Head/Fontanelles	normocephalic, AF _____ x _____, posterior fontanelle patent	_____
EENT:	RR normal bilaterally, conjunctiva clear, nares patent, normal oral mucosa, ears normal placement	_____
Neck:	full range of motion	_____
Lungs:	clear bilaterally	_____
CV:	normal S1, S2, RRR without murmur normal femoral pulses	_____
Abdomen:	soft, no hepatosplenomegaly or masses	_____
Extremities:	symmetric, no deformities	_____
Hips:	negative Barlow/Ortolani, > 60° abduction	_____
Genitourinary:	<u>Male</u> : testes descended, circ/uncirc <u>Female</u> : normal external genitalia	_____
Neurologic:	moves all extremities symmetrically, normal tone, responds to clap, positive moro, grasp/suck/root/toe grasp	_____

ASSESSMENT:

PLAN:

1. Newborn transition
 - Normal
 - Concerns _____
2. Immunizations
 - Hep B #1 done at hospital
3. Circumcision
 - NA
 - Requested after discussion
 - Declined after discussion
 - Done
4. Tobacco exposure
 - Yes No
5. Newborn Screening
 - Recommended at 7-14 days of age (or)
 - 2nd specimen must be at least 48hrs after the first
6. _____

- _____
- _____
- _____
- Discussed recommended schedules, risks and benefits
- Hep B #1 ordered today
- Circumcision scheduled _____
- Cessation counseling
- Exposure avoidance
- Referral _____
- 2nd specimen drawn today
- Pt to return for lab only between 7-14 days of age
- _____
- _____

Next visit at 2 - 4 weeks

Provider Signature

Date