PEDIATRIC PATIENT INTRODUCTION: NEONATE

INFANT'S NAME: _____ MOTHER'S NAME: _____
Last First Middle Last First Middle

AHC NUMBER: _____ FATHERS NAME: _____
Last First Middle

ADDRESS: _____ CITY/TOWN: _____

PROV: _____ POSTAL CODE: _____ HOME PHONE: _____

MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____

EMAIL: _____ EMAIL REMINDERS: Y__N __ BIRTHDATE (DD/MM/YY): _____

AGE: _____ SEX: _____ BIRTH WEIGHT: _____ CURRENT WEIGHT: _____

OF SIBLINGS: _____ BIRTH LENGTH: _____ CURRENT LENGTH: _____

TYPE OF BIRTH:

VAGINAL:	Natural	CESAREAN:	Uncomplicated	PRESENTATION:	Breech
	Vacuum		Complicated		Posterior
	Forceps				Transverse

PREGNANCY HISTORY: _____

_____

LABOUR AND DELIVERY HISTORY: _____

_____

_____

WAS THIS INFANT A PREMATURE DELIVERY (LESS THAN 37 WEEKS GESTATION)? _____YES _____ NO

APGAR SCORES: _____/_____ WAS THERE PRESENCE AT BIRTH OF: Jaundice (Yellow)
Cyanosis (Blue)

CONGENITAL ANOMOLIES/DEFECTS: _____

INFANT FEEDING: _____Breast _____Bottle _____Formula _____Brand

#OF HOURS SLEEP PER NIGHT: _____ QUALITY OF SLEEP: _____ Good _____ Fair _____ Poor

OBSTETRICIAN/MIDWIFE: (Name) _____ (Located at) _____

PEDIATRICIAN/FAMILY MD: (Name) _____ (Located at) _____

DATE OF LAST VISIT TO MD: _____ PURPOSE OF VISIT: _____

HAS YOUR INFANT BEEN SEEN BY A LACTATION CONSULTANT? _____

PURPOSE OF THIS APPOINTMENT: _____

_____

_____

_____

HAS YOUR INFANT BEEN TREATED ON AN EMERGENCY BASIS/BEEN HOSPITALIZED: _____

DATES: _____

DESCRIBE: _____

_____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THIS INFANT:

FOLLOW AN OBJECT WITH HIS/HER EYES _____ RESPOND TO SOUND _____ HOLD HEAD UP _____

HAS THIS INFANT EXPERIENCED:

MUSCULOSKELETAL:
- ☐ Head Shape Concerns
- ☐ Head Position/Favouring
- ☐ Spinal Concerns
- ☐ Hip Concerns
- ☐ Leg/Feet Concerns
- ☐ Shoulder/Arm Concerns
- ☐ Clavicle Concerns
- ☐ Fractures
- ☐ Other _____

NEUROLOGICAL:
- ☐ Paralysis
- ☐ Seizures
- ☐ Spina Bifida
- ☐ Genetic Syndrome
- ☐ Meningitis
- ☐ Erb's Palsy (arm)
- ☐ Seizures
- ☐ Hypotonia
- ☐ Other _____

GASTRO-INTESTINAL:
- ☐ Digestion Concerns
- ☐ Colic
- ☐ Reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Stool Appearance
- ☐ Other _____

GENERAL:
- ☐ Lactation Issues
- ☐ Breastfeeding Difficulties
- ☐ Rupture/Hernias
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Sleep Problems
- ☐ Other _____

PLEASE DO NOT WRITE BELOW THE LINE

PREGNANCY HISTORY: _____

_____

_____

_____

DELIVERY HISTORY: _____

_____

_____

_____

_____

PRESENT HISTORY: _____

_____

_____

_____

_____

_____

_____

_____

SURGERY: _____

MEDICATIONS: _____

FAMILY HISTORY: _____