Northwest PRIMARY CARE

NEWBORN: 0-7 DAYS
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB:_____ Male Female

Physician Signature: _____

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your baby?	◯ NO	◯ YES
Has your baby had any illnesses since hospital discharge?	◯ NO	◯ YES
Are they excessive spitting or vomiting?	◯ NO	◯ YES
Are they excessively crying (more than 3 hours/day)?	◯ NO	◯ YES
Do they have severe nasal stuffiness?	◯ NO	◯ YES
Do you have concerns about skin color or rash?	◯ NO	◯ YES
Did you know that a rectal temperature of 100.4 is a fever?	◯ YES	◯ NO
Could you take a rectal temperature if necessary?	◯ YES	◯ NO
Feeding/ Nutrition		
Is your baby breast feeding well?	◯ YES	◯ NO
How often?		
For how long? (minutes)		
Is your baby taking formula well?	◯ YES	◯ NO
How often?		
How many ounces?		
Which formula?		
Are you feeding your baby anything other than breast milk or formula?	◯ NO	◯ YES
Elimination		
Do they have problems with bowel movements (going poop)?	◯ NO	◯ YES
Do they have problems urinating (peeing) at least five times per 24 hours?	◯ NO	◯ YES
Sleep		
Do you have questions about sleep habits?	◯ NO	◯ YES
Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	◯ NO	◯ YES
If there are other children in the house, are they adjusting well to the newborn?	◯ YES	◯ NO
Are you having family stress?	◯ NO	◯ YES
Do you ever worry that your family will go hungry?	◯ NO	◯ YES

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Development		
Does your baby turn and/or calm to your voice?	◯ **YES**	◯ **NO**
Does your baby's eyes follow your face a little bit?	◯ **YES**	◯ **NO**
Does your baby move their arms and legs well?	◯ **YES**	◯ **NO**
Does your baby suck, swallow, and breathe easily when eating?	◯ **YES**	◯ **NO**
Safety		
Does your baby sleep on his/her back?	◯ **YES**	◯ **NO**
Does your baby sleep in a bassinet or crib and not parents' bed?	◯ **YES**	◯ **NO**
Does your baby ride in a rear facing safety seat, in the back seat?	◯ **YES**	◯ **NO**
Is your baby exposed to anyone who smokes?	◯ **NO**	◯ **YES**
Are there working smoke detectors in the home?	◯ **YES**	◯ **NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	◯ **NO**	◯ **YES**
Has a family member or contact had a positive TB skin test (PPD)?	◯ **NO**	◯ **YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	◯ **NO**	◯ **YES**
Has your baby traveled to a high-risk country for more than a week?	◯ **NO**	◯ **YES**
Birth History		
Weight at birth?		
Full term?	◯ **YES**	◯ **NO**
Passed the hearing test at birth?	◯ **YES**	◯ **NO**
Received the Hepatitis B vaccine at birth?	◯ **YES**	◯ **NO**
Any problems in the nursery?	◯ **NO**	◯ **YES**
Was your baby breech?	◯ **NO**	◯ **YES**