ONE-MONTH PARENT OBSERVATION

Name:_____ Birth date:_____ Today's date:_____

List any medications your baby has taken this week:
If nursing, list any medications you have taken this week
How is feeding going?
Breast-feeding: How often? _____How long?_____
Have you breast fed a child prior to this? Y/N
Any concerns?

Bottle-feeding: How often?_____ How much?_____
What formula?_____ With iron? Y/N
Any concerns?

Is spitting up frequent or painful for your baby? Y/N
Are stools hard or soft or ever difficult to pass? Y/N
Is there any diaper rash or irritation? Y/N
Is fussiness a problem? Y/N
Any congestion or stuffy nose? Y/N
What is baby's sleep routine?
How long will baby sleep at a time?
What position does baby sleep in? Back/Side/Stomach
Is your baby getting "tummy time" each day? Y/N
Do you have concerns about baby's head shape? Y/N
Does your baby react to light? Y/N
Does your baby react to voices or noise? Y/N
Are siblings getting along well with the baby? Y/N
Is your car seat properly fitted in the rear seat, facing the rear? Y/N
Any questions about your car seats proper installation? Y/N
Is your water temperature turned down to 120◦ F? Y/N
Are there any smokers in your home? Y/N

Med list: Rx,OTC, vitamins, inhaled, herbs, supplements

Name	Dose

Do you feel sad, overwhelmed, anxious, angry or upset? Y/N
So you sleep when the baby is sleeping? Y/N
Many new moms get some degree of post partum depression. Please let us know if this is happening to you so we can help!

Please list any other questions or concerns you would like to discuss today:
_____
_____
_____

Provider Signature: _____