COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

Newborn Information ONLY

Parents CHWP Provider: _____

Was this Patient Adopted? Yes____ No ____

Is this patient In Foster Care? Yes____ No____
(If yes, please provide ALL legal documentation at the time of the visit.)

BABYS HEALTH HISTORY:

Time of Birth: _____

Weight: _____ Length: _____

Number of weeks at Delivery: _____

Any jaundice at Birth? Yes____ No _____

Hospitalized after birth? Yes____ No ____

Hospital: _____

If yes, why? _____

Was a hearing test done at the hospital? Yes___ No ____

Breastfeeding: _____ Formula Feeding: _____ Other: _____

MALES ONLY

Circumcision: Yes____ No _____ If Yes, What Date: _____

Questions concerning your baby?

1. _____

2. _____

3. _____