

Infant Clinical History

theCradle
Fax #: (847) 773-1701

Infant's name: _____

Statistics at Birth

Date of birth: _____ Time of birth: _____ Gender: M F

Gestation age: _____ per exam or by dates APGAR Scores: _____

Weight: _____ Length: _____ Head circumference: _____

Unusual Events / Abnormalities

Resuscitation: None PPV Stimulation Free flow Oxygen given: Yes No
If yes, duration: _____

Abnormalities: _____

Tests / Screening Performed

Neonatal (PKU) screening (date & time drawn): _____

Toxicology screening (date & results): _____

Jaundice? No Yes if yes, Bilirubin results: _____

Blood type: _____ Rh factor: _____ Coombs: _____

Hepatitis B Vaccine (date): _____

Other pertinent data, labs or tests: _____

Care of Baby

Formula: Similac Enfamil Other: _____ Frequency: 3-5 hrs Other: _____ Amount: ad lib Other: _____

Symptoms of feeding intolerance? No Yes If yes, explain _____

Signature

Date