



Patient Name _____ DOB _____

Risk Assessment 2 – 5 days

Concerns about how child sees	No	Yes	Concerns
Follows parent/caregiver face	Yes	No	Comment
Can suck, swallow, & breathe easily	Yes	No	Comment
Responds to parent/caregiver voice	Yes	No	Comment

Hip dysplasia risk:

Was baby breech in the last month of pregnancy?	No	Yes	Unknown	Comment
Was your child a multiple (twin, triplet, etc?)	No	Yes	Unknown	Comment
Is there a family history of hip dysplasia?	No	Yes	Unknown	Comment
Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?)	No	Yes	Unknown	Comment

Anticipatory Guidance:

Sleeps on back	Yes	No	Comment
Sleeps in crib or bassinet	Yes	No	Comment
Does baby eat well	Yes	No	Comment
Has 6 – 8 wet diapers per day	Yes	No	Comment
Regular car seat use	Yes	No	Comment
Car seat rear facing	Yes	No	Comment
Home and car are smoke-free environment	Yes	No	Comment
Know how to take baby's temp rectally	Yes	No	Comment
Both parents up to date on TDap (whooping cough vaccine)	Yes	No	Comment
Vitamin D Supplement regularly	Yes	No	Comment