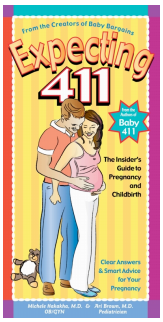

Birth/Delivery Record

Number of weeks gestation: _____

Baby's birth weight: _____

Baby's weight on day of discharge from hospital or birthing center: _____

Baby's length: _____

Baby's head circumference: _____

- Did you have a vaginal delivery? Yes No
- Did you have forceps or vacuum assisted delivery? Yes No
- Did you have a Caesarian delivery (C–section)? Yes No
  If yes, why? _____
- Were there any complications at delivery? Yes No
  If yes, what: _____
- APGAR Scores: _____at 1 minute of life _____at 5 minutes of life
- Were there any complications with the baby during the first few days of life? Yes No
  If yes, what: _____
- If you are a Group B Strep carrier and had a vaginal delivery, did you get pretreated with antibiotics before delivery? Yes No
- Did your baby receive a Hepatitis B vaccine? Yes No
- If applicable, was your baby circumcised? Yes No

Screening Tests:

- If tested, what is your baby's blood type? _____
- Was there any incompatibility (Coombs positive) between your blood type and your baby's? Yes No
- Did your baby pass his newborn hearing screen? Yes No
- Did your baby have a blood test done for jaundice? Yes No
  If yes, what was the bilirubin level?_____
- Were any other tests that need to be followed up on? Yes No
  If yes, specify:_____