Beckman and Associates

Healthy Baby Follow Up – Oral Motor Background Information

Patient Name: _____ **Patient Date of Birth:** _____

Parent / Legal Guardian Name: _____

Date: _____ **Clinician:** _____

GESTATIONAL HISTORY

Length of Gestation: _____

Illness / Hospitalization / Falls (Maternal):

_____

Medications (Maternal): _____

Other Concerns: _____

LABOR

Duration: _____ circle one Spontaneous Induced _____ Hours of Pitocin C-Section

Medications/Anesthesia/Oxygen (Maternal) _____

Fetal Monitor in Place? circle one YES NO Fetal Distress Noted?: _____

Other Concerns: _____

DELIVERY

Problems Breathing (Baby)? circle one YES NO Oxygen Required (Baby)?: _____

Delivered via Mask or Endotracheal? _____

Duration of Oxygen Use? _____

Problems Sucking at Birth? circle one YES NO By Day 3? _____

Non-Oral Intake? circle one YES NO Type? _____

Jaundice? circle one YES NO Treatment? _____ Duration? _____

Other Concerns: _____

Gastrointestinal? _____ Circulatory? _____ Respiratory? _____

Vision Testing? _____ Hearing Testing? _____

INTAKE

Breast _____ Bottle _____ Feeding Position _____

If Bottle, what type of Bottle? _____

What type of Nipple? circle one Preemie Regular Enlarged hole Cross Cut Haberman

Average Intake per Feeding _____ Oz _____ Minutes Average Intake per Day _____

Type of Formula _____

Constipation? circle one YES NO How Treated? _____

Reflux? circle one YES NO How Treated? _____

HEALTH SINCE BIRTH

Illness/Hospitalization/Operations _____

Intake during Hospitalization? circle one Oral Non-Oral Type? _____ Duration? _____

Ear Infection? circle one YES NO How Treated? _____

Seizures? circle one YES NO How Treated? _____

Medications? _____

ADDITIONAL CONCERNS _____