Newborn Exam

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gestational age: _____ Birth weight: _____

Apgar scores: _____ Blood type: _____

Family history:

HISTORY

Details of pregnancy:

Labor and delivery information:

Complications:

GENERAL APPEARANCE

Skin color:

Activity level:

Responsiveness:

HEAD

Head circumference:

Fontanelles:

Scalp:

Shape:

Sutures:

NECK AND CLAVICLES

Range of motion:

Presence of masses:

Clavicles:

EYES

Symmetry:

Set/shape:

Red light reflexes:

EAR, NOSE, MOUTH, THROAT

Ear set/shape:

Preauricular pits:

Nasal shape/patency:

Palate:

Gums:

Lips and tongue:

THORAX AND BREASTS

Thorax shape:

Nipples:

Work of breathing:

LUNG AND HEART

Breath sounds:

Heart sounds:

Femoral pulses:

ABDOMEN AND UMBILICUS

Bowel sounds:

Liver:

Spleen:

Kidneys:

Umbilical cords:

GENITALIA

Labia/Penis:

Hymen/Testicles:

Anus:

TRUNK AND SPINE

Symmetry:

Skin lesions:

Masses:

EXTREMITIES

Upper

Mobility:

Deformity:

Stability:

Lower

Mobility:

Deformity:

Stability:

NEUROLOGICAL

Suck:

Grasp (hands and feet):

Moro:

RECOMMENDATIONS

Specify below:

ADDITIONAL NOTES

Specify below:

Healthcare professional's name: _____

Signature:

Date: _____ dd / mm / yyyy