

My Newborn Care Diary

Baby's Name: _____ Days of Age: _____ Baby's Med Record #: _____

Eating				Sleeping			Consoling	Voiding / Stooling		Extra Comments
Time of baby's feeding (start to finish)	Breast feeding (total # minutes)	Bottle feeding (total # mL)	Was baby able to feed well within 10 min of showing hunger? (If no, please describe)	Time when baby fell asleep	Time when baby woke up	Did baby sleep for one hour or more? (If no, please describe)	Did baby console within 10 min & stay consoled for at least 10 min? (If no, please describe)	Check box for pee	Check box for poop (please describe)	Share any extra symptoms you have seen or concerns/needs that you have to help care for your baby

This content was developed by Bonny Whalen, MD and the staff at the Children's Hospital at Dartmouth-Hitchcock and The Northern New England Perinatal Quality Improvement Network (NNEPQIN).