What is normal in the first week newborn

Feeding often is normal, even when it feels constant

In the first week, frequent feeding is expected. Many breastfed newborns feed 8 to 12 times in 24 hours, and some cluster feeds occur close together, especially in the evening or during growth-related changes. Formula-fed babies may feed somewhat less often, but they still need regular intake and close observation. A newborn stomach is small, colostrum is concentrated, and early feeding also helps stimulate milk production.

Newborns may be sleepy in the first 24 hours after birth, then become more alert and hungry. Some babies need gentle waking for feeds, particularly if they are jaundiced, premature, small, or recovering from a difficult birth. Normal feeding cues include stirring, opening the mouth, turning the head, rooting, hand-to-mouth movements, and sucking. Crying is a late hunger cue and can make latching or coordinated feeding harder.

If breastfeeding, it is common to feel uterine cramping during feeds, nipple tenderness while learning latch, and uncertainty about how much milk the baby is receiving. Helpful signs include audible or visible swallowing, relaxed hands after feeding, and increasing wet and dirty diapers over the week. Painful latch, cracked nipples, persistent sleepiness at the breast, or very

short ineffective feeds are reasons to seek lactation or medical support.

Weight loss and regain have a typical pattern

Most newborns lose weight during the first few days because they pass urine and stool, adjust fluid balance, and begin feeding outside the womb. A modest loss is common, and many babies begin gaining again as milk intake increases. Many newborns are expected to return to birth weight by about 10 to 14 days, although the exact timeline depends on gestational age, birth circumstances, feeding effectiveness, and medical factors.

Weight should be interpreted by a healthcare professional together with diaper output, jaundice, alertness, feeding quality, and clinical exam. A number alone is not the whole story. Your baby's clinician may recommend a weight check, feeding assessment, or bilirubin measurement if weight loss is higher than expected or if the baby appears dehydrated or lethargic.

At home, avoid trying to diagnose feeding adequacy from weight alone unless you have been specifically instructed to do home weights. Instead, track feeding frequency, duration or volume if applicable, wet diapers, stools, and your baby's level of wakefulness. Bring these observations to newborn visits; they are medically useful and often reassuring.

Diapers tell an important story

Urine output usually increases across the first week. A common pattern is at least one wet diaper on day one, two on day two, three on day three, and progressively more after that, with many babies producing about six or more wet diapers per day once feeding is well established. Urine should generally become paler as intake improves.

In the first days, some babies have orange or brick-red staining in the diaper called urate crystals. This can occur when urine is concentrated, especially before milk volume increases. A small amount early on may be normal, but persistent urate crystals, fewer wet diapers than expected, or signs of dehydration should be discussed with a clinician.

Stools also change dramatically. The first stools are meconium: thick, sticky,

and black or dark green. Over the next days, stools usually transition to greenish-brown and then to yellow, seedy stools in many breastfed babies. Formula-fed babies may have stools that are yellow, tan, or brown and more paste-like. Normal stool frequency varies, but in the first week, the overall trend toward more stooling and lighter color is important.

Call for advice if diapers are much fewer than expected for age.
Seek care for blood in stool, very pale or white stool, or persistent black stool after the meconium period.
Ask for feeding support if stools are not transitioning and the baby is sleepy or feeding poorly.

Sleep, waking, and crying are variable

Newborn sleep is usually irregular. Many babies sleep 14 to 18 hours in 24 hours, but not in long adult-like blocks. Sleep often comes in short cycles, and the baby may wake frequently for feeding, comfort, diaper changes, or no obvious reason. Some newborns are very sleepy after birth, while others have alert periods followed by deep sleep.

Active sleep can look surprising. A sleeping newborn may twitch, stretch, grimace, smile briefly, make sucking movements, or breathe irregularly for short periods. These movements are typically part of immature neurologic regulation and rapid eye movement sleep. Normal newborns also startle easily because of the Moro reflex, especially with sudden sounds, position changes, or a feeling of falling.

Crying increases and decreases in patterns that may not always match hunger or pain. In the first week, babies often cry for feeding, skin-to-skin contact, warmth, burping, a diaper change, or help settling. Soothing strategies include holding the baby close, swaddling safely if appropriate, offering a feed, gentle rocking, white noise, and skin-to-skin contact. If crying is high-pitched, inconsolable, associated with poor feeding, fever, breathing difficulty, or a change in responsiveness, seek medical advice promptly.

Breathing sounds can be noisy but should not be labored

Newborns are preferential nose breathers, so mild congestion, snorting,

sneezing, and squeaky noises are common. Sneezing often clears amniotic fluid, mucus, or environmental irritants and does not necessarily mean infection. Hiccups are also common and usually harmless.

It is also common for breathing rhythm to vary. Some newborns have brief pauses followed by faster breaths, especially during sleep. However, normal irregularity should not include persistent distress. The important distinction is effort. A baby who is breathing comfortably may sound noisy but should not be persistently pulling in at the ribs, flaring the nostrils, grunting with each breath, turning blue around the lips or tongue, or struggling to feed because of breathing.

Because newborn respiratory problems can progress quickly, trust your instincts if the breathing looks wrong. Contact your baby's clinician or emergency services depending on severity. Videos can sometimes help clinicians understand intermittent noises, but do not delay urgent care to record a symptom.

Skin color, jaundice, and common newborn rashes

Newborn skin often changes during the first week. Hands and feet may look bluish or cool at times, especially when the baby is cold; this is called acrocyanosis and can be normal if the lips, tongue, and central body remain pink and the baby is otherwise well. Mild peeling, dry skin, and mottling can also occur as the baby adapts to life outside the uterus.

Several benign newborn rashes are common, including small white bumps on the nose called milia and blotchy red patches with tiny pale centers, often called erythema toxicum. These typically resolve without treatment. Avoid applying medicated creams or home remedies unless a healthcare professional recommends them.

Jaundice, a yellow color of the skin or eyes, is common in newborns because bilirubin metabolism is still maturing. Mild jaundice can be expected, but it needs monitoring because high bilirubin levels can be dangerous. Jaundice that appears in the first 24 hours, spreads quickly, involves marked sleepiness or poor feeding, or seems to deepen should be assessed promptly. Babies with prematurity, bruising, blood group incompatibility, or feeding difficulties may need closer follow-up.

Temperature, cord care, and body findings

Newborns do not regulate temperature as efficiently as older children. A typical axillary temperature is often around 36.5 to 37.5´℃, but your clinician may give specific instructions on how and when to measure. Over-bundling can cause overheating, while under-dressing can lead to low temperature. Skin-to-skin contact, appropriate layers, and a safe sleep environment help maintain stability.

The umbilical cord stump usually dries, darkens, and falls off within the first couple of weeks. A small amount of dried blood can be normal. Keep the area clean and dry, fold the diaper away if needed, and avoid pulling the stump. Seek care for spreading redness, swelling, pus, foul odor, fever, or tenderness around the cord.

Temporary genital and breast findings are also common because of maternal hormones. Newborn girls may have white vaginal discharge or a small amount of blood-tinged discharge. Babies of any sex can have mild breast swelling. These findings usually resolve on their own. Do not squeeze swollen breast tissue, and ask a clinician if there is redness, warmth, fever, or significant swelling.

Early development is subtle but meaningful

In the first week, development is mostly about regulation: feeding, sleeping, maintaining temperature, and responding to caregivers. Newborns can often focus best at close range, roughly the distance to a caregiver’s face during feeding. They may turn toward familiar voices, calm with skin-to-skin contact, and show a strong sucking reflex.

Normal reflexes include rooting, sucking, grasping, stepping-like movements when held upright with support, and the Moro startle reflex. These reflexes are signs of the immature nervous system doing what it is designed to do. They are not skills to train; they are automatic responses that clinicians may check during newborn exams.

Parents sometimes worry because their baby does not seem interactive yet. In the first week, brief alert periods, gaze toward faces, calming with contact,

and feeding cues are meaningful forms of communication. The most important caregiving tasks are responsive feeding, safe sleep, warmth, diaper tracking, and seeking help when something feels medically concerning.