1 -

Month Well Check Questionnaire

Name _____

DOB _____

Chief Complaint Please circle or print appropriate answer

Do you have any concerns about your baby?

Yes No

If so, explain _____

Does your baby have any special health care needs?

Yes No

If so, explain _____

Has your baby seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

If so, explain _____

Has your baby had any procedures or tests done since your last visit?

Yes No

If so, explain _____

How are you adjusting to the baby?

Well Fair Poor

In the last2 weeks, has the mother been feeling down, sad, hopeless, or overwhelmed? Does the mother have little interest or pleasure in doing things?

Not at all Several days More than half the days Nearly every day

Who helps to take care of the baby or household chores? _____

How are the baby's siblings adjusting to the baby?

N/A Well Fair Poor

How many people, other than this baby, are living in this baby's home? _____

Including: Mother Father Sibling(s) Significant Other of Mother Significant Other of Father Maternal Grandparent(s) Paternal Grandparent(s) Other Family Member(s) Friend(s)

If this baby is not living with both biological parents, what is the living situation?

Joint Custody Single Custody Family Member Foster home Adoptive Home Other

If other, explain _____

Besides your baby's birth, have there been any other major changes in your family lately?

Yes No

What kind of change?

Separation Divorce Move Return to Work/School Job Change

Loss of Job Money Problems Significant Illness Death in the Family Other

If other, explain _____

What are your plans for work?

Mother staying home Father returning Father staying home

Mother returning

What are your plans for childcare?

Family member Babysitter/Nanny Daycare

When will/did child care start? _____/_____/_____(mm/dd/yyyy)

Does your baby live with anyone or spends time with anyone who smokes? Does anyone smoke in the care your baby travels in?

Yes No

Has a family member or contact had a positive tuberculin skin test?

Yes No

Was your child born in a country with a high risk of tuberculosis (countries other than the US, Canada, Australia, New Zealand or Western Europe?)

Yes No

Has your child traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?

Yes No

1 - Month Well Check Questionnaire

Review of Systems Please circle or print appropriate answer

Is your child breastfeeding?

Yes breastmilk only Yes breastmilk supplemented by formula No

How many minutes does your child breastfeed for per feeding? _____

How many feedings does your child have per day? _____

Do you have question about pumping or storing breastmilk?

Yes No

Is your child drinking formula?

Yes No

How many ounces of formula does your child drink per feeding? _____

How many feeding does your child have per day? _____

What brand of formula does your child drink?

Enfamil Good Start Similac Generic Brand Other

If other, explain _____

What kind of water do you use to mix with the formula?

Tap Well Bottled Ready-to-Feed

Is the formula your child drinks iron-fortified?

Yes No Unknown

Does your child take vitamins or supplements?

Yes No

If so, describe _____

Does your child have any problems with feeding?

Yes No

If so, describe _____

Do you have concerns that your child is frequently vomiting, throwing up, or spitting up?

Yes No

If so, describe _____

How many times a day does your child vomit, throw up, or spit up? _____

Do you have concerns regarding your child's urination or peeing?

Yes No

If so, describe _____

Do you have concerns regarding your child's bowel movements or pooping?

Yes No

If so, describe _____

How many hours does your child sleep a night? _____

How many naps does your child take per day? _____

Is your child put to sleep on their back?

Yes No

Is your child learning to fall asleep on their own?

Yes No

Does your child sleep in their own crib or bed?

Does your child sleep with a bottle or have the bottle propped up when sleeping?

Yes No

Has anyone in your child's family ever had significant cavities?

Yes No

Do you have concerns about your child's vision?

Yes No

If so, describe _____

Do you have concerns about your child's hearing?

Yes No

If so, describe _____

Does your child have tummy time while awake?

Yes No

How many hours a day does your child watch TV or other electronic devise screen like a computer, tablet, or game console?

None 2 Hours or less 3 Hours or more

Do you have concerns about your child's development?

Yes No

If so, describe _____

Do you play and talk with your baby while they are awake?

Yes No

Do you have concerns about your child's behavior?

Yes No

If so, explain _____

Are you able to identify your child's different cries?

Yes No

Are you able to soothe your child?

Yes No

Does your child use a pacifier?

Yes No

When your baby rides in a car, do you use a car seat?

Every time Occasionally Never

Where, in the care, is the car seat located?

Front Seat Back Seat

Which way is the car seat facing?

Forward Rear

Do you have emergency numbers that are easy to find?

Yes No

Are there working smoke detectors in the house?

Yes No

Does your baby wear jewelry or a pacifier around their neck?

Yes No

Does your baby play with small objects, latex balloons, or plastic bags?

Yes No

Are the cords to window blinds out of your child's reach?

Yes No

Is your baby left alone on high places like changing tables or countertops?

Yes No

Is your baby left alone in the tub?

Yes No

Is the temperature of your hot water at or below120 degrees Fahrenheit in the places your child frequents? (For example, at home, at babysitter's or daycare)

Yes No

Do you drink or carry hot liquids while holding your baby?

Yes No