Patient Name

Date of Birth

Well Baby Check: 1 month visit questionnaire

Interval History:

Has your baby had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No ☐ Yes ☐

Did your baby pass the hearing test done in the hospital? Yes ☐ No ☐ Unsure ☐

Did your baby have a Newborn Screen done in the hospital (test where blood is taken from the heel)? Yes ☐ No ☐ Unsure ☐

Development:

Does your baby regard your face (starting to focus with his/her eyes)? Yes ☐ No ☐

Does your baby respond to voices or sounds? Yes ☐ No ☐

Does your baby move both arms and legs equally? Yes ☐ No ☐

Do you have any concerns about how your baby sees or hears? No ☐ Yes ☐

Does your baby lift his/her head when lying on his/her tummy? Yes ☐ No ☐

Staying Healthy/Safety/Dental Health/Tobacco Exposure:

Does your home have a working smoke detector? Yes ☐ No ☐

Have you turned your water temperature down to low-warm (less than 120 degrees)? Yes ☐ No ☐ N/A ☐

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes ☐ No ☐

Do you always put your baby to sleep on her/his back? Yes ☐ No ☐

Do you always stay with your baby when she/he is in the bathtub? Yes ☐ No ☐

Do you always place your baby in a rear-facing car seat in the back seat? Yes ☐ No ☐

Is your car seat the right one for the age and size of your baby? Yes ☐ No ☐

Does your baby spend time with anyone who smokes? No ☐ Yes ☐

Parental Support:

During the past 2 weeks, how often have you been bothered by the following problems:

Feeling down, depressed, irritable, or hopeless?

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

Little interest or pleasure in doing things?

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

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No ☐ Yes ☐
This includes all countries ***other than*** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate ***for one month or more***? (Countries other than those listed above) No ☐ Yes ☐

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No ☐ Yes ☐ Unsure ☐

Is your child immunosuppressed (currently or planned)? No ☐ Yes ☐
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

How many hours does your baby sleep at night? _____hours

How many hours does your baby nap throughout the day? _____hours

Nutrition/Physical Activity:

For Breastfeeding: How many minutes of feeding per side? _____minutes

For formula/bottle feeding: How many ounces per feeding? _____oz

If you are giving formula, what brand are you using?

_____

How often does your baby feed? Every_____hours

How many feedings in 24 hours? _____feedings

Do you give your baby a bottle of anything except formula or breast milk? No ☐ Yes ☐

Do you have any concerns about your baby's feeding? No ☐ Yes ☐

Elimination:

Does your baby have at least 6-8 wet diapers in 24 hours? Yes ☐ No ☐

Does your baby have bowel movements on a regular basis with a normal (soft/loose) consistency? Yes ☐ No ☐

Please list any medications or supplements your baby is taking, including vitamin D:

_____

Who lives in the home with your baby? _____

Who provides daytime care for your child? _____

Please list any major family medical issues: _____

_____

Please list any known Allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

_____

_____

Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

Ver.12-12-17