1 Month Well Child Check-Up

Person completing form: Mother___ Father____ Grandparent____ Other _____

Parental Concerns:
_____
_____

Relationships:
Who lives in the home with the child?_____
Number of siblings? _____

TB Risk Assessment:
Known exposure to person with TB? No____Yes____
If yes, who? _____

Smoking:
Are there smokers at home? No____Yes____
If yes, do they smoke outside only? No____Yes____

Home Environment & Safety:
Type of dwelling: (circle one) Apartment House Trailer Other
Heat source: (circle one) Gas Electric Hot water Other
Water source for dwelling: (circle one) City/municipal Well
Known Lead exposure in home? No____Yes____
If yes, was it removed? No____Yes____
Home built before 1950? No____Yes____
Any home renovations in last 6 months? No____Yes____
Infant car seat rear facing in vehicle? No____Yes____
Does your dwelling have:
Carbon monoxide detectors No____Yes____
Smoke detectors No____Yes____
Pool/spa at home? No____Yes____
Pets or animals at home? No____Yes____
If yes, what types? _____
Firearms in the home? No____Yes____
If yes, are they in locked storage? No____Yes____

Sleep Habits:
Any concerns? No____Yes____
If yes, please explain_____
Does your child take naps? No____Yes____
Does your child sleep in bed with parents? No____Yes____
Does your child sleep through the night? No____Yes____
Does your infant sleep on their back? No____Yes____

You can complete this information online. Ask the receptionist about signing up for the Patient Portal!

Nutrition:
Any concerns? _____
Is your child on the WIC program? No____Yes____
Does your child get breast milk? No____Yes____
How often are they feeding? _____
How long are they feeding?_____
Does your child get formula? No____Yes____
What type? _____
How many ounces per feeding? _____
How often? _____

Elimination:
Any concerns about urine output? No____Yes____
Any concerns about bowel movements? No____Yes____

Developmental:
Focus on face Yes____No____
Lifts head Yes____No____
Startles to touch or noises Yes____No____
Turns head toward sound Yes____No____

Family History:
Is there any family history of mental illness, emotional problems, drug or alcohol abuse? If so, please describe _____
_____
_____