One Month – well child care **Patient Name:_____D.O.B_____**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Do you have any questions or concerns about your baby since we saw you last?_____
_____
_____

Feeding

How is the baby fed?_____ ▢Breast Fed ▢Formula _____
How much and how frequent?_____
If breastfeeding, is the baby receiving a vitamin D supplement? ▢ Yes ▢No
Are you able to tell when your baby is hungry?_____ ▢ Yes ▢No
Can you hear the baby swallow?_____ ▢ Yes ▢No
How many urine soaked diapers does the baby have every 24 hours? _____
How many bowel movements does the baby have every 24 hours? _____
What do the stools look like (soft, seedy, loose)? _____

Sleep Pattern

Is your baby sleeping on its back?_____ ▢ Yes ▢No

How many hours a day?_____

Safety

Is your child's car seat rear facing and in the back seat?_____ ▢ Yes ▢No
Is your child exposed to tobacco smoke?_____ ▢ Yes ▢No
Are there any improperly stored firearms in the home?_____ ▢ Yes ▢No
Is the hot water temperature set low enough
to prevent accidental burns?_____ ▢ Yes ▢No
Are there working smoke detectors in the home?_____ ▢ Yes ▢No

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Please complete both sides of this form