

# Well Child Check: 1 Month Visit



Childs Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues.

Does your child lift his/her head while lying on the tummy?	YES	NO	UNSURE
Does your child move arms equally and legs equally?	YES	NO	UNSURE
Does your child smile?	YES	NO	UNSURE
Does your child seem to look at faces?	YES	NO	UNSURE
Does your child follow objects with his/her eyes?	YES	NO	UNSURE
Does your baby drink:			
	Breast Milk	Formula	Unsure
If you are giving formula, how many ounces does your child take in 24 hours? _____ oz.			
Type of formula?			
Do you always place your infant to sleep on the back?	YES	NO	UNSURE
Does your baby always sleep in a crib or bassinet?	YES	NO	UNSURE
Do you have working smoke alarms in your home?	YES	NO	UNSURE
Are there smokers in your home?	YES	NO	UNSURE
Do you have safety concerns for your home?	YES	NO	UNSURE
If so, what are your concerns?			
Is your child on any medications or supplements including vitamins? If so, please list below:			
Has mom been feeling sad, anxious or depressed often?	YES	NO	UNSURE

### Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or close contact had tuberculosis disease?	YES	NO	UNSURE
Has a family member had a positive tuberculosis test?	YES	NO	UNSURE

Do you have any other concerns about your child's development or any other concerns you would like to discuss with the provider? If YES, please describe below: