CHILDREN FIRST
DUMFRIES PEDIATRICS

Well Child Check: 1 Month Visit

Your Child's Name: _____

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

Does your child lift the head when 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 or her eyes?	Yes	No	Unsure
Does your baby drink breast milk or formula?	Breast milk	Formula	Both

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 the 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?	No	Yes	Unsure
Do you have any safety concerns in your home?	No	Yes	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, hopeless or depressed often?	Yes	No	Unsure

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	Yes	No	Unsure
Has a family member had a positive tuberculosis test?	Yes	No	Unsure

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? If so, please describe:	Yes	No

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