



Health Maintenance Questionnaire

1 MONTH

PATIENT NAME _____ BIRTH DATE ____/____/____ AGE TODAY _____

PARENTS _____ TODAY'S DATE ____/____/____

PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION	PHYSICIAN'S COMMENTS
HISTORY Describe any recent injuries or illnesses: _____ List medications taken routinely: <input type="checkbox"/> none Note any new stresses in the family: _____ Will your baby go to day care? <input type="checkbox"/> No <input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other: How many kids? Are there smokers in your baby's home or daycare? <input type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room	☞ Put to bed when drowsy ☞ Note self quieting ☞ Increased crying over next 6-12 weeks, esp. at night. <input type="checkbox"/> Discussed diaper rash care. <input type="checkbox"/> Call with rectal temp >100.5° <input type="checkbox"/> Discussed use of saline nose drops / nasal suctioning. <input type="checkbox"/> Discussed risks of 2 nd hand smoke.
NUTRITION FORMULA FEEDING: How many ounces in 24 hrs? _____ What formula? _____ BREAST FEEDING: How many months do you plan to breast feed? How many times does baby nurse in 24 hours? How many minutes is each feeding? Y N <input checked="" type="checkbox"/> Is baby fed on demand? <input checked="" type="checkbox"/> Does baby latch on well? <input type="checkbox"/> Have you given supplemental formula? <input checked="" type="checkbox"/> Have you pumped breast milk? How many of each per day: spit ups _____ wets _____ stools _____	Shaded items are new for the 1 mo check-up. BREAST FEEDING RECOMMENDATIONS <input type="checkbox"/> Expect at least one feeding at night. <input type="checkbox"/> Should gain 4-7oz per week. <input type="checkbox"/> 8-12 feedings in 24 hrs is typical. <input type="checkbox"/> Feeding duration may shorten. <input type="checkbox"/> Don't restrict feedings / Feed on demand. <input type="checkbox"/> Expect growth spurt at 6-8 wks old. <input type="checkbox"/> Don't overuse the pacifier. Is baby hungry? <input type="checkbox"/> Back to work? Pump and freeze milk properly. <input type="checkbox"/> If needed, introduce bottle or cup. <input type="checkbox"/> Mom should not diet. Drink to thirst. <input type="checkbox"/> Vitamins usually not necessary.
	STOOLING EXPECTATIONS <input type="checkbox"/> BREAST FED: Expect 6-8 wets and 3-4 loose mustard curdy stools per day. Stool frequency may decrease now. <input type="checkbox"/> FORMULA FED: Stool frequency is variable, but should not be hard balls.

PHYSICAL EXAM	LAB	IMMUNIZATIONS
Ht _____ Wt _____ HC _____ VS: _____ Check if normal: <input type="checkbox"/> Head/Fontanel <input type="checkbox"/> Nose <input type="checkbox"/> Eyes/Red reflexes <input type="checkbox"/> Mouth <input type="checkbox"/> Ears <input type="checkbox"/> Throat <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Lungs <input type="checkbox"/> Back <input type="checkbox"/> Heart <input type="checkbox"/> Hips <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Extremities <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Genitalia <input type="checkbox"/> Neurologic	State Newborn Screens <input type="checkbox"/> Normal Supplemental Newborn Screens <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Discussed but declined Other: _____	<input checked="" type="checkbox"/> Health Department <input type="checkbox"/> HepB Other: _____

ASSESSMENT

1. NORMAL GROWTH and DEVELOPMENT. More information on other side.

2. _____

3. _____

4. _____

5. _____

PLAN

1. Follow up at 2 months for Health Review. Anticipatory handouts given.

2. _____

3. _____

4. _____

5. _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

DEVELOPMENT AND BEHAVIOR	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's development or behavior?	
Y N <input type="checkbox"/> <input type="checkbox"/> Does baby respond to sound by blinking, crying, quieting or startling? <input type="checkbox"/> <input type="checkbox"/> Does s/he look at your face and follow you with his/her eyes to the midline? <input type="checkbox"/> <input type="checkbox"/> Does s/he respond to your voice and face? <input type="checkbox"/> <input type="checkbox"/> Does baby enjoy looking at a mobile? <input type="checkbox"/> <input type="checkbox"/> Does s/he move arms and legs equally? <input type="checkbox"/> <input type="checkbox"/> Does baby lift his/her head slightly during "tummy time?" <input type="checkbox"/> <input type="checkbox"/> Can s/he be consoled from crying most of the time? (Colic may set in at this time. Crying 2-3 hrs/day is normal.) <input type="checkbox"/> <input type="checkbox"/> Have parents spent any time alone?	
S L E E P	How many hours does baby sleep at a time? (3-4 hrs is typical) _____
	Y N <input type="checkbox"/> <input type="checkbox"/> Can baby stay awake for at least 1 hour? <input type="checkbox"/> <input type="checkbox"/> Do you put him/her down when drowsy to teach self-quieting? <input type="checkbox"/> <input type="checkbox"/> Do you put baby down on his/her back? <input type="checkbox"/> <input type="checkbox"/> Do you avoid bulky bedding in the crib? <input type="checkbox"/> <input type="checkbox"/> Do you alternate baby's head position to prevent flattening of the skull?
	Where does baby sleep?

SAFETY AWARENESS	
Please review the shaded items, which are new for the 1 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/>	
Y N <input type="checkbox"/> <input type="checkbox"/> Do you always monitor baby while s/he's in the car seat? <input type="checkbox"/> <input type="checkbox"/> Is baby's car seat rear facing in the back seat? (Do this until 1 yr old AND 20 lbs) <input type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> <input type="checkbox"/> Do you monitor baby closely around young siblings or pets? <input type="checkbox"/> <input type="checkbox"/> Do you avoid putting necklaces or pacifiers on strings around baby's neck? <input type="checkbox"/> <input type="checkbox"/> Are you aware that shaking your baby could cause permanent brain damage?	

Who answered the above questions? _____ Thank you for helping us help you and your child!!
Please put this paper in the box hanging outside the door so that we know you are finished!