1 Month Well Child Check Name_____

Allergies_____Current Medications_____

Is your baby healthy?	**Yes**	**No**_____
Do you feel your baby is developing normally?	Yes	No_____
Do you think your baby can hear?	Yes	No_____
Do you think your baby can see?	Yes	No_____
Does your baby have normal stools?	Yes	No_____
Does your baby have at least 4-6 wet diapers/day?	Yes	No_____
Does your baby sleep a 2-4 hour stretch at night?	**Yes**	**No**_____
Does your baby cry excessively?	No	Yes_____
If breastfeeding—are you having any problems?	No	Yes_____
How often is your baby nursing?		_____
If formula feeding—Type of formula?		_____
How many ounces/how often?		_____
Does your baby take a vitamin or supplement?	**Yes**	**No**
Are you feeling depressed or "down" much of the time?	No	Yes_____
Has there been any recent change to your family structure?	No	Yes_____
Does your home have a safe, adequate heat source?	Yes	No
Does anyone in your household smoke ?	No	Yes _____
Did you get your baby's 2nd PKU?	Yes	No
Do you have working carbon monoxide detectors?	Yes	No
Where does your baby sleep?		_____

Do you have any other concerns?_____

_____

Development (Do not complete if given Ages and Stages Questionnaire)

Does your baby respond to sounds?	Yes	No
Does your baby look at your face?	Yes	No
Does your baby follow objects or faces with his/her eyes?	Yes	No
When laying on his/her tummy, can your baby lift his/her head briefly?	Yes	No
Are your baby's arms/legs in a flexed position?	Yes	No
Does your baby move his/her arms/legs?	Yes	No