OPTUM®

Department of Pediatrics
1-719-522-1134 TTY **711**

Well-check questionnaire

1 month well-check

Patient name: _____ **DOB:**_____ **Today's date:** _____

Medications:_____ **Allergies:** _____

Mother's maiden name: _____

Are you breast or formula feeding?_____

Name of formula: _____Ounces per feeding: _____

Of wet diapers a day:_____ # Of stools a day: _____

Is your baby eating at least every three hours?	☐ No	☐ Yes
Are you having difficulty feeding your baby?	☐ No	☐ Yes
Does your baby sleep at least 5 hours at a stretch at night?	☐ No	☐ Yes
Does your baby sleep in a crib or bassinet?	☐ No	☐ Yes
Does your baby sleep on his/her back?	☐ No	☐ Yes
Do you think your baby sees and hears?	☐ No	☐ Yes
Will your baby be entering a daycare home or center?	☐ No	☐ Yes

Is your baby always in a car seat when riding in a vehicle?	☐ No	☐ Yes
Is your hot water heater turned down to 120?	☐ No	☐ Yes
Does your home have smoke and carbon monoxide detectors?	☐ No	☐ Yes
Is your baby exposed to second hand smoke at home, in car or at daycare?	☐ No	☐ Yes
Are there any firearms in the home? If so, are they locked up?	☐ No	☐ Yes
Are there any pets in the home?	☐ No	☐ Yes
Do you feel depressed or have a family history of depression?	☐ No	☐ Yes
Do you know what to do if your child chokes?	☐ No	☐ Yes

Is your baby:

Quick to agitation?	☐ No	☐ Yes
Difficult to soothe?	☐ No	☐ Yes
Irritable with feedings?	☐ No	☐ Yes

Any questions or concerns: _____