



Health Maintenance Questionnaire

1 MONTH

Today's Date: _____

PATIENT NAME: _____

Birth Date: _____

PARENTS: _____

Age Today: _____

PARENTS' CONCERNS

List concerns you have? 1.

- 2.
- 3.
- 4.
- 5.

Please check any body areas that concern you:

- | | | | |
|---------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Heart | <input type="checkbox"/> Bones | <input type="checkbox"/> Hormones |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Joints | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Intestines | <input type="checkbox"/> Muscles | <input type="checkbox"/> Glands |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Brain | <input type="checkbox"/> Immunity |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Genitals | <input type="checkbox"/> Nerves | |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> Mental Health | |

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

PATIENT INFORMATION

HISTORY

Describe any recent injuries or illnesses:

List medications taken routinely: none

Note any new stresses in the family:

Will your baby go to day care? No Home based Center based Nanny

How many kids? _____ Other: _____

Are there smokers in your baby's home or day care? No outside other room

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

Is baby fed on demand?

Does baby latch on well?

Have you given supplemental formula?

Have you pumped breast milk?

- Call with rectal temp >100.50
 - Saline nose drops / nasal suctioning.
 - Avoid 2nd hand smoke.
- Breast Feeding Recommendations**
- 8-12 feedings in 24hrs is typical
 - Nurse at least every 3 hours during the day so baby will sleep longer at night.
 - Don't go more than 5hrs at night without removing milk (pump if baby sleeps longer)
 - If baby is supplemented with pumped breast milk or formula → pump (supply : demand)
 - Should gain at least 7oz per week or 1oz per day.
 - Request a weight check if baby is excessively sleepy, fussy, or not clearly gaining weight.
 - If using a nipple shield, do weight checks half way between regular well baby check –ups.
 - Needs at least 24oz of milk each day
 - Spitting up does not always indicate over feeding, but rather an immature and “loose” valve between the esophagus and stomach.
 - Don't restrict feedings / Feed on demand
 - Don't overuse the pacifier. Is baby hungry?
 - Consider pumping each morning after nursing to freeze mlk for return to work.
 - Introduce a recommended bottle if desire.
 - Mom should not diet. Drink to thirst.
 - Vitamin D 1ml per day if fed mostly breast milk.

How many of each per day: spit ups: _____

wets: _____

stools: _____

- STOOLING EXPECTATIONS**
- BREAST FED: Expect 6-8 wets and 3-4 loose mustard curdy stools per day. Frequency may decrease.
 - FORMULA FED: Stool frequency is variable, but should not be hard balls.

PHYSICAL EXAM

Ht _____ Wt _____ HC _____ VS: _____

Head/Fontanel	Nose	Lungs	Back
Eyes/Red reflexes	Mouth	Heart	Hips
Ears	Throat	Femoral pulses	Extremities
	Neck	Abdomen	Skin
	Chest	Genitalia	Neurologic

LAB

Newborn Screens

Normal

Pending

Other: _____

IMMUNIZATIONS

Health Department

ASSESSMENT

PLAN

PLEASE COMPLETE OTHER SIDE OF FORM

Patient Name:

Birth Date:
1 month

DEVELOPMENT AND BEHAVIOR

Yes No Are you concerned about your child's development or behavior?

Y N

- Does baby respond to sound by blinking, crying, quieting or startling?
- Does s/he look at your face and follow you with his/her eyes to the midline?
- Does s/he respond to your voice and face?
- Does baby enjoy looking at a mobile?
- Does s/he move arms and legs equally?
- Does baby lift his/her head slightly during "tummy time"?
- 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.)
- Have parents spent any time alone?

**S
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P**

How many hours does baby sleep at a time? (3-4 hrs is typical)

Y N

- Can baby stay awake for at least 1 hour?
- Do you put him/her down when drowsy to teach self-quieting?
- Do you put baby down on his/her back?
- Do you avoid bulky bedding in the crib?
- Do you alternate baby's head position to prevent flattening of the skull?

Where does baby sleep?

SAFETY AWARENESS

The shaded items are new for the 1 month visit.

Y N

- Do you always monitor baby while s/he's in the car seat?
- Is baby's car seat rear facing in the back seat?
- Is the water temperature in your house less than 120 degrees?
- Do you have a fire escape plan?
- Do you check your smoke detectors regularly?
- Do you monitor baby closely around young siblings or pets?
- Do you avoid putting necklaces or pacifiers on strings around baby's neck?
- Are you aware that shaking your baby could cause permanent brain damage?

Car seat is rear facing until 2 yrs old or until they reach the highest weight or height allowed by car seat's manufacturer.

Who answered the above questions?

Thank you for helping us help you and your child!!