MUNDELEIN PEDIATRICS

1 Year Well Exam

Name: _____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Breastfeeding/ Formula: Yes/No Concerns: _____
2. Switched to whole milk: Yes/No Concerns: _____
3. Solids (rice cereal/pureed fruits or vegetables, finger foods) Yes/No Concerns: _____
4. Sleeps through the night: Yes/No Concerns: _____
   (____) hours per night
   (____) hours from naps during the day
5. Urinating well: Yes/No Concerns: _____
6. Normal bowel movements: Yes/No Concerns: _____
7. Sleeps on back: Yes/No Concerns: _____
8. Rides in a rear-facing car seat in the back seat: Yes/No
9. Takes Vitamins: Yes/No Product Name: _____
10. Emergency room visits: Yes/No
11. Illness since last visit: _____
12. Developmentally: plays pat-a-cake, feed self-crackers, bangs two objects in hands together, drinks from a sippy cup, thumb-finger grasp, imitate sounds, says mama/dad -specific, walks holding on, walks by self, stands alone, becomes shy or anxious with strangers, makes postural adjustments when dressing

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Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Firearms at home: Yes/No If yes, are safety precautions taken: Yes/No
4. Daycare: None/Relative/Center/Babysitter
5. Primary care taker: Mom/Dad/Grandparents
6. Household composition:
   Adult(Names/Ages): _____
   Children(Names/Ages): _____
7. New health problems in parents or siblings: _____
8. Past vaccine reactions: Yes/No
9. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

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