MUNDELEIN PEDIATRICS

1 Month Well Exam

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

Please circle the answer that most appropriately describes your child:

1. Breastfeeding: Yes/No Concerns: _____
2. Formula feeding: Yes/No Concerns: _____
3. Awakens at night to feed: Yes/No Concerns: _____
4. Excessive spitting or vomiting: Yes/No Concerns: _____
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: follows moving objects with eyes, begins to smile, equal movements of all extremities, holds head up momentarily when on tummy

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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. Daycare: None/Relative/Center/Babysitter
4. Primary care taker: Mom/Dad/Grandparents
5. Household composition:
   Adult(Names/Ages): _____
   Children(Names/Ages): _____
6. New health problems in parents or siblings: _____
7. Past vaccine reactions: Yes/No
8. Sibling rivalry: Yes/No
9. Post-partum depression in mom (crying a lot, sad, depressed): Yes/No

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

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