1 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's...

1. 1. Feedings? ☐ Yes ☐ No
   ☐ Breast ☐ Formula
2. Excessive spitting, vomiting, or back arching with feedings? ☐ Yes ☐ No
3. Bowel movements? ☐ Yes ☐ No
4. Nasal stuffiness, congestion or wheezing? ☐ Yes ☐ No
5. Skin color or rashes? ☐ Yes ☐ No
6. Crying more than 3 hours a day? ☐ Yes ☐ No
7. Sleep habits ☐ Yes ☐ No
8. Growth ☐ Yes ☐ No
9. Development? ☐ Yes ☐ No

Answer the following:

10. Is your child exposed to tobacco smoke? ☐ Yes ☐ No
11. Have you been depressed or crying lately? ☐ Yes ☐ No
12. Are your infants bowel movements white or gray or blood streaked? ☐ Yes ☐ No
13. Does your baby co-sleep with you in bed? ☐ Yes ☐ No
14. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No

Does your child...

15. Look at your face or the ceiling fan or lights? ☐ Yes ☐ No
16. Startle at loud noises? ☐ Yes ☐ No
17. Lift his/her head off your shoulder when held upright? ☐ Yes ☐ No
18. Move all extremities equally well? ☐ Yes ☐ No
19. Bottle fed infants: Is your child getting over 30 ounces per day? ☐ Yes ☐ No

Please answer the following:

20. Do you have any help with the baby? ☐ Yes ☐ No
21. Are you getting enough rest? ☐ Yes ☐ No
22. Does your child ride in a rear-facing infant car seat? ☐ Yes ☐ No
23. Do you know infant CPR? ☐ Yes ☐ No
24. Does your baby sleep with a pacifier? ☐ Yes ☐ No
25. Does your baby sleep on his/her back? ☐ Yes ☐ No
26. Have both parents/caregivers had the Tdap vaccine? ☐ Yes ☐ No
27. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season? ☐ Yes ☐ No

1 Month Questionnaire

Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

1. Are you giving vitamin D? ☐ Yes ☐ No
2. Breast feeding mothers, are you taking a multivitamin with iron? ☐ Yes ☐ No
3. Are you having any problems nursing? ☐ Yes ☐ No
4. Do you need help from our lactation specialists? ☐ Yes ☐ No
5. Do you need help with preparations to return to work? ☐ Yes ☐ No
6. Will your baby take a bottle? ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ☐ Yes ☐ No
2. Do any family members have a positive TB test? ☐ Yes ☐ No
3. Was your child or any family member born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk? ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your infant is less than 12 months old with chronic lung or congenital heart disease ☐ Yes ☐ No
2. Your infant was a preemie of 28 weeks or less and is less than 12 months old ☐ Yes ☐ No
3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months ☐ Yes ☐ No
4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder ☐ Yes ☐ No
5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise ☐ Yes ☐ No
6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant ☐ Yes ☐ No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ☐ Yes ☐ No

_____

_____

_____

_____

_____