One Month Pre-visit Questionnaire

Patient Name________________________ Date________________

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Baths: (every other day) (daily)

Formula: ___________________ Ounces per feeding? ____ Every how many hours? ____

# of stools Daily______ # of voids Daily_____ # of hours sleeping at ONE time_____

Feeding Concerns:

____

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things?____

Have there been any major changes in your family recently other than your baby's birth?

____

Developmental Milestones (circle all that apply)

- ☐ Blinks in reaction to light
- ☐ Responds to sound (startles)
- ☐ Follows objects past midline
- ☐ Vocalizes Coos

Any other questions or concerns you would like to discuss?

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TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was you child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**

Weight______ Temp_________Height_______ Head Circumference________