

**PEDIATRIC HEALTH
ASSESSMENT HEALTH
1 MONTH**

CHILD'S NAME: _____ DATE: _____ AGE: _____

PRESENT CONCERNS/PROBLEMS: _____

ACCOMPANIED BY: _____ RELATIONSHIP: _____

SOCIAL/FAMILY HISTORY

FAMILY SITUATION

Who lives at home? _____

Adjustment to new child. Any problems? _____

Reaction of siblings to new child _____

Work Plans for Mom _____

Child care plans _____

NUTRITION

Feeding: circle Bottle or Breast

Formula Type _____ Breast fed: How often - every _____ hours / number feeds _____ per day

Ounces per Feed _____ Total minutes of breast feeding per feed _____

Hours between feed _____ Feedings/24 hours _____

Is baby taking any vitamins? Yes No If so what type? _____

URINE: Number of wet diapers per day _____

STOOL: Number of bowel movements per day _____

Does baby sleep in own bassinette? Yes No Sleep Position: _____

Behavior: _____

Toxic exposure: Lead Yes No Smokers in household Yes No

Any exposure to anyone with TB or with high risk (born or lived outside the United States, homeless, incarcerated, HIV/drug use)? Yes No

Smoke Detector in house at home? Yes No Car seat always used? Yes No

Development

Motor

Raises head slightly in prone position

Sensory

- Blinks in reaction to bright light
- Follows object to midline
- Responds to sound