

**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