Sutter Health
With You. For Life.

Your Child's Name: _____

One Month Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you.

Does your child lift the head when lying on the tummy?	Yes	No	Unsure
Does your child move arms equally and legs equally?	Yes	No	Unsure
Does your child coo (make "ooh", "aah" sounds)?	Yes	No	Unsure
Does your child smile?	Yes	No	Unsure
Does your child seem to look at faces?	Yes	No	Unsure
Does your child follow objects with his or her eyes?	Yes	No	Unsure

Does your baby drink breastmilk or formula? Breastmilk Formula Both

If you are giving formula how many ounces does your child take in 24 hours? _____oz

Type of formula?_____

Do you always place your infant to sleep on the back?	Yes	No	Unsure
Does the baby always sleep in a crib or bassinette?	Yes	No	Unsure
Do you have working smoke alarms in your home?	Yes	No	Unsure
Are there smokers in your home?	Yes	No	Unsure
Do you have any safety concerns in your home?	Yes	No	Unsure

If so, what are your concerns?_____

Has mom been feeling sad, anxious, hopeless or depressed often?	Yes	No	Unsure

Is your child on any medications or supplements? If so, please list below:

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	Yes	No	Unsure
Has a family member had a positive tuberculin skin test?	Yes	No	Unsure

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider?	Yes	No

If so, what are your concerns?