0-1 Month Visits

NAME	**DATE**

Patient Name	**Date**

This section to be completed by the parent

Was the pregnancy? full term? Y N premature? Y N (# weeks_____)

Complications during pregnancy Y N

Complications during labor or delivery? Y N

Birth Weight Discharge weight Apgar

Did your baby have any complications after delivery? Y N

Safety		
1. Does your baby sleep on his/her back?	**YES**	**NO**
2. Does your child ride in a rear facing car seat?	**YES**	**NO**
3. Do you know infant CPR?	**YES**	**NO**

Are you concerned about your baby's……		
1. Feedings? Breast Y N Formula Y N	**YES**	**NO**
2. excessive spitting or crying?	**YES**	**NO**
3. bowel movements?	**YES**	**NO**
4. nasal stuffiness?	**YES**	**NO**
5. skin color, rashes or lesions?	**YES**	**NO**
6. excessive crying?	**YES**	**NO**
7. lack of response to loud noise?	**YES**	**NO**
8. sleep habits?	**YES**	**NO**
9. cigarette smoke exposure?	**YES**	**NO**

Do you have other concerns you wish to discuss?	**YES**	**NO**

OFFICE USE ONLY

WT HT HC Temp