Newborn to One Year Well Child Form:

Child's Name: _____ DOB:_____

Are there any problems or concerns?

_____

_____

_____

Feeding:

Type of feeding: Breast Bottle Formula:_____

How often? Every 30mins 1 hour 2 hours 3 hours 4 hours 5 hours

If formula feeding how much each time? 0.5 1 2 3 4 5 6 7 8 _____ ounces

How many ounces of formula does your child drink every 24hrs? _____ ounces

If breast feeding, how is it going?_____ Is the infant receiving Vit D drops? Yes No

Is your child eating baby food?

How many servings (1-2tbsp) per day? 1-2 3-4 5-6 7-8 _____

What type of foods do they eat? Infant Cereals Veggies Fruits Meats Table Foods

Any problems with particular foods? _____

Sleep:

What is the longest your baby sleeps for at one time regularly? _____hours

Safety Questions:

Do you use a rear facing five point harness car seat? Yes No

Does anyone in the family smoke? Yes (Who:_____) No

Is the house or dwelling built after 1978 (Lead exposure)? Yes No

Any history of lead exposure or high lead levels in the family? Yes No

Is there any known risk factor for tuberculosis? Yes No

Childcare:

Who cares for the child during the day? Mom Dad Grandparent Daycare _____