

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Health Status Questionnaire – 1 Month**

Baby lives with: mother father both parents other: \_\_\_\_\_

Planned childcare: daycare babysitter stays at home other: \_\_\_\_\_

Breastfeeding? Y N Every \_\_\_\_ hours For \_\_\_\_ minutes per side

Formula feeding? Y N Formula: \_\_\_\_\_ oz every \_\_\_\_ hours

If at least 1/2 the feedings are breastmilk, giving vitamin D supplement? Y N

Any problems feeding? Y N \_\_\_\_\_

Stool pattern: 1X/day 2X/day several/day hard runny soft

Place infant to sleep on back? Y N

Sleep problems: Y N \_\_\_\_\_

Does your baby:

Have equal movements of both sides of body? Y N

respond to stimuli? Y N

smile spontaneously? Y N

look at your face? Y N

Passive smoke exposure: Y N Car seat use: Y N

Smoke detectors: Y N Fire extinguishers: Y N

Do you have any concerns about your baby? \_\_\_\_\_

\_\_\_\_\_