



WELL CHILD CHECK UP: 0 – 11 months

Patient's Name _____ D.O.B. _____ Age _____ Date _____

Interval History:

Has your child been ill since the last check-up? Yes No If yes, please describe below:
(Hospitalization, surgeries, ongoing illness, etc.) _____

What medications, supplements, or vitamins is your child taking, if any? _____

Does your child have any allergies? Yes No What kind? _____

Has your child had a reaction to shots before? Yes No If yes, describe: _____

What concerns or questions do you have about your child, if any? _____

Nutrition:

How is your child's appetite? Good Average Poor

Breastfeeding _____ minutes, every _____ hours, _____ times a day.

Formula _____ ounces, every _____ hours. Name of formula _____

Other (cereal, water, juice, milk, food, etc.)? _____

How many teeth does your child have? _____ Do you brush his/her teeth? Yes No

Does your child eat paint or dirt? Yes No

How many stools a day? _____ Color and consistency? _____

Any problems with feeding, urine output or bowel movements? _____

Development / Language / Motor: *Check box only if YES*

Does your child... Coo Laugh Babble Talk → How many words? _____

Does your child... Hold head up Roll over Sit with help Grab toys

Transfer items from hand to hand Sit alone Crawl on own Pull to stand

Stand alone Walk with help Walk alone Feed him/her self

Safety / Home:

Do you use a car seat? Yes No What position is it in? Rear-facing Forward-facing

Do you have a working smoke detector? Yes No

Is your child exposed to smoke? Yes No Is there a gun in your home? Yes No

Who lives in your house? _____

Any pets? If yes, what kind? _____

Please describe your childcare arrangements: _____

Has anyone physically abused or threatened you or your children? Yes No

TB Screening Questions: Has your child been around anyone ... who has HIV or uses IV drugs? Yes No

... who lives in a group or nursing home? Yes No ... who has traveled to another country? Yes No

... who has been homeless or incarcerated (in jail)? Yes No

Behavior:

What do you do when your child misbehaves? _____

Any behavior problems? Yes No If yes, describe: _____

How many hours does your child sleep at night? _____ During the day? _____

Do you want to discuss (check if Yes): Eating problems Sleep problems

→ Please indicate relationship of person completing form: _____

Signature: _____ Date: _____