Pediatrics Southwest

HEALTH UPDATE SHEET
1 MONTH TO 10 MONTHS
MARK D. TOWNS, M.D.

Child's Name: _____

Date of Birth: _____

INSTRUCTIONS:

In order to give your baby the best care and to help identify your concerns, please answer the following questions. Find the column for your baby's age and fill in today's date. Answer each question by circling yes or no in the appropriate column. If you cannot answer the question, just move to the next one.

CHILD'S CURRENT AGE →	1 - 2 mo.	3 - 4 mo.	5 - 7 mo.	8 - 10 mo.
TODAY'S DATE →				
SINCE HIS/HER LAST WELL-CHILD CHECKUP HERE, HAS YOUR BABY...				
1. Been seen by a doctor, clinic or other specialist besides at his office?	Yes No	Yes No	Yes No	Yes No
2. Had any bad reactions to shots, food or medicine?	Yes No	Yes No	Yes No	Yes No
3. Experienced any important changes for the family - moves, job loss, serious illness, family problems, etc.?	Yes No	Yes No	Yes No	Yes No
SINCE HIS/HER LAST WELL-CHILD CHECKUP, DOES YOUR BABY...				
4. Seem to hear well?	No Yes	No Yes	No Yes	No Yes
5. See to see well?	No Yes	No Yes	No Yes	No Yes
6. Have eyes that cross or turn in or out?	Yes No	Yes No	Yes No	Yes No
7. Have ear drainage or infection?	Yes No	Yes No	Yes No	Yes No
8. Have frequent nasal congestion?	Yes No	Yes No	Yes No	Yes No
9. Have trouble breathing?	Yes No	Yes No	Yes No	Yes No
10. Have problems with feeding or nursing?	Yes No	Yes No	Yes No	Yes No
11. Have problems with stomach or bowels?	Yes No	Yes No	Yes No	Yes No
12. Seem to have trouble urinating?	Yes No	Yes No	Yes No	Yes No
13. Have a problem with skin rashes?	Yes No	Yes No	Yes No	Yes No
14. Have seizures, convulsions, or blackouts?	Yes No	Yes No	Yes No	Yes No
15. Seem generally happy and pleasant to be with?	No Yes	No Yes	No Yes	No Yes
16. Have problems sleeping by themselves or going to bed awake?	Yes No	Yes No	Yes No	Yes No

Please continue on the other side

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	1-2 mo.	3-4 mo.	5-7 mo.	8-10 mo.
CHILD'S CURRENT AGE →				
TODAY'S DATE →				
17. Is your baby behaving in ways that are a problem for you or your family?	Yes No	Yes No	Yes No	Yes No
18. Do you have a reliable person who can help you care for your baby when you need to go out?	No Yes	No Yes	No Yes	No Yes
19. When you take your baby in the care, do you always use a safe car seat that can be firmly held down by seatbelts and faces the rear of the car?	No Yes	No Yes	No Yes	No Yes
20. Have you baby proofed the house yet? (poison control number by phone, stair gates, smoke alarms, plug covers, cabinet and drawer latch, guns locked and stored away from ammunition, water temp <120 degrees, etc.)	No Yes	No Yes	No Yes	No Yes
21. Do you routinely put the baby to sleep on his/her back?	No Yes	No Yes	No Yes	No Yes
22. Do you brush/clean your baby's teeth/gums daily?	No Yes	No Yes	No Yes	No Yes
23. Are there any other issues you are concerned about?	Yes No	Yes No	Yes No	Yes No

DOES YOUR BABY DO THESE THINGS YET?

	1-2 mo.	3-4 mo.	5-7 mo.	8-10 mo.
Looks at faces and follows with eyes?	NO YES	NO YES	NO YES	NO YES
Smile back at you when talked to?	NO YES	NO YES	NO YES	NO YES
Lifts head with support on his/her forearms?		NO YES	NO YES	NO YES
Make cooing sounds?		NO YES	NO YES	NO YES
Hold a toy placed in his/her hand?		NO YES	NO YES	NO YES
Roll over (either way)?		NO YES	NO YES	NO YES
Reach out and get objects?		NO YES	NO YES	NO YES
Turn towards sounds he/she can't see?			NO YES	NO YES
Make consonant sounds (ex: baba, gaga - not just aah, oo, ee sounds)?			NO YES	NO YES
Feed himself/herself crackers or finger foods?				NO YES
Sit alone for five minutes or more?				NO YES
Say "mama" or "dada" sounds?				NO YES
Crawl, creep or scoot?				NO YES
Pull himself/herself up to stand?				NO YES

CHECK WHICH OF THE FOLLOWING YOU ROUTINELY GIVE YOUR BABY:

_____ Breast Feedings
_____ Vitamins
_____ Formula - Which one? _____
How much per 24 hours? _____
_____ Baby Cereal
_____ Fruits
_____ Vegetables
_____ Cow's milk
_____ Meats/Eggs
_____ Table Foods
_____ Desserts (baby or table food)
_____ Bottle IN bed (during night or nap)