

Jessica Davis MD

The New Mom's Family Doctor
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TWELVE MONTH WELL CHILD VISIT

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES			DISCUSSION TOPICS
Yes	No	Overall, I feel confident that my child is doing well	General questions Family Support Childcare arrangements Anticipate colds and viruses Infant temperament *****
Yes	No	I have enough help with the baby	
No	Yes	There have been recent changes or stresses in our family	
No	Yes	My child attends daycare. _____ Days a week?	
No	Yes	Parenting is harder than I thought it would be Who lives with you and the baby? _____	
FEEDING			***** Continue breastfeeding Encourage use of cup Wean from formula to whole milk until age 2 Encourage table foods and self-feeding Cleaning teeth/1st Dentist *****
No	Yes	I have questions about my baby's feeding My baby takes breast milk every ___ hrs, or _____ formula, ___ oz every ___ hrs	
No	Yes	My baby drinks juice _____ oz per day	
Yes	No	My baby eats solid food _____ meals per day. ___ Fruit ___ Vegetables ___ Meat ___ Dessert ___ Finger Foods	
No	Yes	My baby has a bottle at bedtime	
No	Yes	I have questions about teething.	***** Need for bedtime routine Avoid bottle at bedtime Normal variation Change in stools with solids *****
SLEEPING / VOIDING / STOOLING			
Yes	No	I am satisfied with my child's sleep schedule. # naps per day _____ #hrs sleep at night _____ How do you get your baby to sleep? Feeding / Rocking / Pacifier / Self / Other	
No	Yes	My baby wakes up in the middle of the night. To get him/her back to sleep I _____	***** R-PDQ if concerns Increased mobility/exploring Social games/peek-a-boo Talk to / Sing to / Read To Redirect Tantrums Separation/stranger anxiety *****
Yes	No	My baby pees and poops normally. # Wet diapers per day _____ # Stool diapers _____	
BEHAVIOR / DEVELOPMENT			***** Risk of tobacco exposure Assess TB risk Car seat rear facing until at least 20lbs and 1 year old Poison control 800-222-1222 Choking hazards Burn prevention Water safety
No	Yes	I have questions about my child's development	
Yes	No	My baby seems to see and hear well.	
Yes	No	My baby imitates speech and can say at least one word.	
Yes	No	My baby sits up alone / stands holding on / crawls	
Yes	No	My baby can walk	
Yes	No	My baby uses his/her finger and thumb to pick up things	
No	Yes	I have questions about discipline	
PREVENTION			*****
No	Yes	My baby lives with someone who smokes cigarettes	
No	Yes	My child or another person living with us was born outside the U.S. or has traveled to Asia, Mexico, Latin America, or Africa	
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No	Yes	I have a family member who has had Tuberculosis	
Yes	No	My child always rides in a car seat in the back seat	
Yes	No	My baby is never left alone in the car or house	
Yes	No	Our electrical outlets are covered	
Yes	No	Poisons/cleaners/tools/matches are kept locked and/or out of reach	
Yes	No	I have smoke alarms and test them regularly	
Yes	No	We have gates in front of stairs	
Yes	No	My hot water heater is set to 120°F	
No	Yes	I have concerns that my baby is not safe at home or daycare	
No	Yes	Is there anything else you want to discuss today?	
Mortality Leaders: Accidental injuries due to falls, drowning, burns, choking, auto accidents			