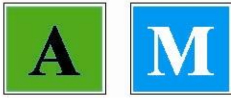

Patient Name_______________DOB__________

Risk Assessment 1 Month

Able to lift head when on tummy	Yes	No	Comment	
Follows parent/caregiver with eyes	Yes	No	Comment	
Recognizes parent's voices	Yes	No	Comment	
Has started to smile	Yes	No	Comment	
Concerns about how child sees	No	Yes		
Hip dyplasia risk:				
Was baby breech in the last month of pregnancy?	No	Yes	Unknown	Comment
Was your child a multiple (twin, triplet, etc?)	No	Yes	Unknown	Comment
Is there a family history of hip dysplasia?	No	Yes	Unknown	Comment
Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?)	No	Yes	Unknown	Comment
TB risk:				
Family members or contact had tuberculosis or positive TB skin test	No	Yes	Unknown	Comment______________
Born in country outside of the United States	No	Yes	Unknown	Comment______________
Traveled or had contact with high TB risk population longer than a week	No	Yes	Unknown	Comment______________
Anticipatory Guidance:				
Sleeps on back	Yes	No	Comment	
Spends time with parent on tummy when awake	Yes	No	Comment	
Regular car seat use	Yes	No	Comment	
Car seat rear facing	Yes	No	Comment	
Home and car are smoke-free environment	Yes	No	Comment	
Do you & baby feel safe at home	Yes	No	Comment	
Do you know how to take baby's temp rectally	Yes	No	Comment	
Parent up to date on TDap (whooping cough)	Yes	No	Comment	
Vitamin D Supplement regularly	Yes	No	N/A	