



PATIENT NAME _____ AGE _____ SEX _____ BIRTH DATE _____ DATE OF EXAM _____

Welcome to you and your infant. Please answer these questions and provide any further information in the column at the right.

(Please explain right-hand column answers here.)

- | | | |
|---|-----------|-----|
| 1. Does your baby seem to be doing well? | Yes | No |
| 2. Is your baby eating well? <input type="checkbox"/> breast <input type="checkbox"/> bottle formula _____ | Yes | No |
| 3. Does your baby cry very often? | No | Yes |
| 4. Does your baby sleep well at night? | Yes | No |
| 5. On a scale of 1 (rested) to 5 (exhausted) how tired are you? | 1 2 3 4 5 | |
| 6. Does your baby: <input type="checkbox"/> Follow you with his/her eyes <input type="checkbox"/> Coo | Yes | No |
| <input type="checkbox"/> Listen to your voice <input type="checkbox"/> Smile at you responsively <input type="checkbox"/> Watch objects | | |
| 7. Does your baby have a baby sitter or go to a day care? | No | Yes |
| 8. Has your baby had any illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 9. Does your baby take any medications or supplements regularly?
What? _____ | No | Yes |
| 10. Have any new stresses or illnesses occurred in the family since your last visit? | No | Yes |
| 11. Do you have any questions about the DTaP, Hepatitis B, HIB, Polio or
Pneumococcal immunizations? | No | Yes |
| 12. Do you always use an approved car seat for the baby? | Yes | No |
| 13. Do you have a working smoke alarm? | Yes | No |
| 14. Have you had formal CPR and First Aid training? | Yes | No |
| 15. Is your baby exposed to tobacco smoke? | No | Yes |
| 16. Please write here 3 or 4 descriptive words that apply to your baby.
_____ | | |
| 17. Are there any special questions you would like to ask today? | No | Yes |
| 1) _____ | | |
| 2) _____ | | |
| 3) _____ | | |