



PATIENT NAME _____ AGE _____ SEX _____ EXAM. DATE _____

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

1. Does your baby seem to be healthy and developing normally? Yes No
2. Is your baby drinking well? Breast Bottle Formula _____ Yes No
3. Have you begun feeding solids yet? No Yes
4. Does your baby sleep well at night? Yes No
5. Do your baby's eyes wander or cross? No Yes
6. Is your baby in day care? No Yes
7. Has your baby had any illnesses, injuries, hospitalizations or surgery? No Yes
8. Does your baby take any medications or supplements regularly?
(Circle) Vitamins Fluoride Other: _____ No Yes
9. Has your baby had any reaction to previous immunizations? No Yes
10. Do you have any questions about the DTaP, Polio, HIB, Hep. B or
Pneumococcal immunizations? No Yes
11. Do you always use an approved car seat for the baby? Yes No
12. Do you have a working smoke alarm? Yes No
13. Have you had formal CPR and First Aid training? Yes No
14. Is the baby exposed to tobacco smoke at home, in the car, or in day care? No Yes
15. Have there been any new stresses or problems in the family? No Yes
16. Please write here 3 or 4 descriptive words that apply to your baby.

Yes No
17. Does your baby: Listen to music Respond to sounds
 Laugh, smile, coo Reach for things Grasp a rattle
 Follow you with his/her eyes Look at, play with hands
 Bring hands together in front of his/her face Roll over
Yes No
18. Are there any special questions you would like to ask today? No Yes
 - 1)
 - 2)
 - 3)

(Please explain right-hand column answers here.)