



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.

(Please explain right-hand column answers here.)

- | | | |
|--|-----|-----|
| 1. Does your baby seem to be healthy and developing well? | Yes | No |
| 2. Is your baby drinking well? Breast Bottle Formula _____ | Yes | No |
| 3. Is your baby taking solid foods well?
Which ones? _____ | Yes | No |
| 4. Does your baby sleep well at night? | Yes | No |
| 5. Do your baby's eyes wander or cross? | No | Yes |
| 6. Has your baby had any serious illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 7. Does your baby take any medications or supplements regularly?
(Circle) Vitamins Fluoride Other: _____ | No | Yes |
| 8. Has the family had any major stresses or new illnesses recently? | No | Yes |
| 9. Is your baby cared for by a babysitter or day care? | No | Yes |
| 10. Does s/he have any unusual or bothersome behaviors? | No | Yes |
| 11. Has your baby had any reactions to previous immunizations? | No | Yes |
| 12. Do you have any questions about today's immunizations? | No | Yes |
| 13. Do you always use an approved car seat for the baby? | Yes | No |
| 14. Do you have a working smoke alarm? | Yes | No |
| 15. Have you had formal CPR and First Aid training? | Yes | No |
| 16. Do you have the poison control information phone number at home? | Yes | No |
| 17. Is the baby exposed to tobacco smoke at home, in day care, or in the car? | No | Yes |
| 18. Please review the red sheet Lead Exposure Questionnaire . Are any of those risk factors present for your child? | No | Yes |
| 19. Does your baby: | Yes | No |
| <input type="checkbox"/> Recognize mother and prefer her to others | | |
| <input type="checkbox"/> Grasp objects <input type="checkbox"/> Transfer things from hand to hand | | |
| <input type="checkbox"/> Bang on things <input type="checkbox"/> Rake or paw at small objects | | |
| <input type="checkbox"/> Babble <input type="checkbox"/> Sit with support | | |
| <input type="checkbox"/> Roll back-to-front <input type="checkbox"/> Roll front-to-back | | |
| 20. Are there any special questions you would like to ask today? | No | Yes |
| 1) | | |
| 2) | | |
| 3) | | |