



PATIENT NAME _____ AGE _____ SEX _____ EXAM. DATE _____

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

(Please explain right-hand column answers here.)

- | | | |
|--|-----|-----|
| 1. Does your baby seem to be healthy and growing well? | Yes | No |
| 2. Do you have any concerns about your child's development? | No | Yes |
| 3. Is your baby drinking well? <input type="checkbox"/> breast <input type="checkbox"/> bottle formula _____ | Yes | No |
| 4. Is your baby taking solid foods well yet? | Yes | No |
| 5. Does your baby sleep well at night? | Yes | No |
| 6. Does s/he have any unusual or bothersome behaviors? | No | Yes |
| 7. Has your baby had any serious illnesses, injuries, hospitalizations or surgery? | No | Yes |
| 8. Does your child have any allergies? _____ | No | Yes |
| 9. Does your baby take any medications or supplements regularly? (Circle) Vitamins Fluoride Other: _____ | No | Yes |
| 10. Do you clean your baby's teeth or gums regularly? | Yes | No |
| 11. Has the family had any major changes or stresses recently? | No | Yes |
| 12. Is your baby cared for by a babysitter or day care? | No | Yes |
| 13. Do you have any questions about the blood test (for anemia) that may be recommended at this examination? | No | Yes |
| 14. Do you always use an approved car seat for the baby? | Yes | No |
| 15. Do you have a working smoke alarm? | Yes | No |
| 16. Have you had formal CPR and First Aid training? | Yes | No |
| 17. Do you have the poison control information phone number at home? | Yes | No |
| 18. Is the baby exposed to cigarette or tobacco smoke at home, in day care, or in the car? | No | Yes |
| 19. Please review the Lead Exposure Questionnaire . Are any of those risk factors present for your child? | No | Yes |
| 20. Does your baby: <input type="checkbox"/> Sit alone <input type="checkbox"/> Stand holding on
<input type="checkbox"/> Poke with index finger <input type="checkbox"/> Work to get to toys
<input type="checkbox"/> Play bye-bye and peek-a-boo <input type="checkbox"/> Respond to his/her name
<input type="checkbox"/> Say dada and mama sounds <input type="checkbox"/> Imitate speech sounds
<input type="checkbox"/> Feed self with fingers <input type="checkbox"/> Drink from a cup | Yes | No |
| 21. Are there any special questions you would like to ask today?
1)
2)
3) | No | Yes |