

Child's Name: \_\_\_\_\_ Child's age: \_\_\_\_\_ Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

**Review of Nutrition:**

	Yes	No
Is your child drinking whole milk, limited to no more than 20 ounces per day?	( )	( )
Have you weaned your child from the bottle?	( )	( )
Is juice/sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child take a supplement that contains vitamin D regularly?	( )	( )
On average, does your child eat fast food one or more times per week?	( )	( )

**Family and Social History:**

	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

**Preventative Health/Risk Factors:**

	YES	NO
How many hours of TV or videos is your child exposed to per day?		
Does your child always ride in a car seat, in the back seat, facing backwards	( )	( )
Do you or anyone who cares for your child, or anyone in the home smoke?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB) or is at high risk for TB (visited Africa, Asia, Latin America, Caribbean Country, been homeless or jailed, IV user, HIV positive)?	( )	( )
Is your water heater set to less than 120 degrees?	( )	( )

**Oral Health:**

	Yes	No
Have you found a dentist for your child yet?	( )	( )

**Behavioral/Mental Health:**

	Yes	No
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well without snoring?	( )	( )
Do have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
If so, do you need assistance finding daycare/early Head	( )	( )

**Developmental Surveillance:**

	Yes	No
<b>Social-Emotional:</b>		
Waves bye-bye?	( )	( )

Tries to do what you do?	( )	( )
Cries when you leave?	( )	( )
Plays peek-a-boo?	( )	( )
Hands you a book to read?	( )	( )
<b>Communicative:</b>		
Speaks 1-2 words?	( )	( )
Tries to make the same sounds as you?	( )	( )
Looks at things you are looking at?	( )	( )
<b>Cognitive:</b>		
Follows simple directions?	( )	( )
<b>Physical Development:</b>		
Bangs toys together?	( )	( )
Pulls to stand?	( )	( )
Stands alone?	( )	( )