

Baby's Name _____ Baby's Age _____ Date _____

Person completing the form _____ Relationship to the patient _____

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

Review of Nutrition:	Yes	No
Is your baby feeding well?	()	()
Is your baby breast fed? If yes, how often?	()	()
Are you giving vitamins and are you offering anything else to your baby to eat or drink?	()	()
Is your baby Formula fed?	()	()
If yes, what formula?	()	()
If yes, how many ounces per feeding?		
If yes, how often?		

Family and Social History:	Yes	No
Are there any illnesses in the family that we are not already aware of?	()	()
Are there any major stressors in the family (illness, moves, death, separation)?	()	()
If you have other children, are they having a hard time adjusting to the new baby?	()	()

Preventative Health/Risk Factors:	Yes	No
Does your child sleep only in his/her own bassinet or crib?	()	()
Does your child always ride in a car seat, in the back seat facing backwards?	()	()
Do you, anyone who cares for your child or anyone in your home smoke?	()	()

Behavioral/Mental Health:	Yes	No
Does your child cry more than you expected?	()	()
Do you 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 a daycare?	()	()

Developmental Surveillance:	Yes	No
Social/Emotional		
If upset, able to calm?	()	()

Communicative	Yes	No
Recognizes your voice?	()	()
Starting to smile?	()	()

Cognitive	Yes	No
Follows your face with eyes?	()	()

Physical Development		
Lifts head when on tummy?	()	()