Jame_____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your baby's…	YES	NO
1. feedings ☐ Breast ☐ Formula _____	☐	☐
2. excessive spitting or vomiting	☐	☐
3. bowel movements	☐	☐
4. straining with stools	☐	☐
5. straining or crying with voiding	☐	☐
6. nasal stuffiness, congestion or wheezing	☐	☐
7. skin color or skin rashes (circle)	☐	☐
8. excessive crying	☐	☐
9. sleep habits	☐	☐
Does he/she sleep on back?	☐	☐
Does your child…		
10. smile at the sound of your voice or seeing your face	☐	☐
11. coo or vocalize when you talk to him / her	☐	☐
12. watch you as you walk across the room	☐	☐
13. startle at loud noises	☐	☐
14. turn head toward direction of sound	☐	☐
15. move all extremities equally well	☐	☐
16. hold head upright for a short time	☐	☐
17. Is your child exposed to cigarette smoke?	☐	☐
18. Do you have any help with the baby?	☐	☐
19. Are you getting enough rest?	☐	☐
20. Have you been sad, depressed or crying excessively?	☐	☐
21. Will your child be attending day care?	☐	☐
22. Does your child ride in a rear-facing infant car seat?	☐	☐
23. Do you know infant CPR?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

Parent's Signature _____ Date _____

Parent's section reviewed by _____

History

☐ Previous concerns, consults and procedures reviewed

(Interval: ☐ No Change) Concerns _____

Current Medications _____

Drug Allergies ☐ Yes ☐ No _____

Past / Social / Family History (Interval: ☐ No Change)

Provider Comments

Anticipatory Guidance

General	*Nutrition*	*Injury Prevention*
☐ Growth /Dev.	☐ Breast	☐ Car seat
☐ Immunizations	☐ Formula	☐ Falls
☐ Stools/Urine	☐ Solids (4-6 Mo.)	☐ No strings around neck
☐ Sleep (back, alone)	☐ Vitamins	☐ No shaking
☐ Crib/Mattress	☐ No honey	☐ Burns-hot water
☐ Pacifier use	☐ No bottle prop	☐ Smoke alarms
☐ Ed. Handouts	☐ No microwave	☐ Gun safety