Name	D	Date//
THIS SECTION TO BE COMPLETED BY PARENT		History Previous concerns, consults and procedures reviewed
		•
Personal Social History		(Interval: No Change) Concerns
Are you concerned about your baby's YES N	ю	
1. feedings    Breast    Formula	] [	
☐ Solids? ☐ ☐	]	
2. excessive spitting or vomiting	]	
3. bowel movements	] [	
4. straining with stools	]	
5. straining or crying with voiding	]	
6. congestion or wheezing		
		Current Medications
		Current Medications
8. excessive crying		
10. sleep habits	ľ	Drug Allergies
Does he/she sleep in a room alone?	]	
Does he/she sleep through the night?	]	Past / Social / Family History (Interval:   No Change)
If not, does he/she feed during the night?	<b>.</b>	
Does your child		
11. crow, squeal, babble and imitate speech	]	
12. respond to his / her name, say "no-no" and "bye-bye"	]	
13. make sounds such as "mama" and "dada"		
14. repeat sounds or gestures for attention	]   .	
15. seem to hear well	]	
16. play pat-a-cake or peek-a-boo	]	
17. move all extremities equally well	]	
18. explore objects by shaking, banging, throwing	]	
19. try to pick up objects with thumb and forefinger	ו נ	
20. sit alone for a long time	]	
21. go from tummy to sitting by self	]	
22. crawl, creep and scoot on bottom		
23. pull to a standing position	]	Provider Comments
24. Do you have smoke alarms in your house?		
25. Is your child exposed to cigarette smoke?		
26. Is your child attending day care?	]	
27. Does your child ride in a rear-facing infant safety seat?		
28. Do you know infant CPR?	].   .	
T 1 C		
Lead Screen		
Does your child		
1. Live in or regularly visit a house that was built before 1950?	,	
(day care, baby sitter or relative)	J .	
2. Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?	]	
3. Have a sibling or playmate who now has or did have lead poisoning?	,	
Do you have any concerns you wish to discuss?	1.	Anticipatory Guidance
	•	General Nutrition Injury Prevention
	-	☐ Growth / Dev. ☐ Breast ☐ Car seat
	-	☐ Immunizations ☐ Formula ☐ Burns-hot water
		□ Behavior       □ Solids       □ Smoke alarms         □ Stranger anxiety       □ Finger foods       □ Electric outlets
		☐ Stranger anxiety ☐ Finger foods ☐ Electric outlets ☐ Sleep ☐ Vitamins/Fl. ☐ No infant walkers
	· .	☐ Mattress (lower) ☐ Juice ☐ Poisons
Parent's Signature Date		☐ Passive smoke ☐ Water safety
Parent's section reviewed by		☐ TB risk ☐ Sun exposure ☐ Ed. Handouts ☐ Gun safety
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