Name_____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your baby's…	YES	NO
1. feedings ☐ Breast ☐ Formula _____	☐	☐
Have you started solids? _____	☐	☐
2. excessive spitting or vomiting	☐	☐
3. bowel movements	☐	☐
4. straining with stools	☐	☐
5. straining or crying with voiding	☐	☐
6. congestion or wheezing	☐	☐
If present, does this clear with sleeping?	☐	☐
7. skin color or skin rashes (circle)	☐	☐
8. excessive crying	☐	☐
9. overall development	☐	☐
10. sleep habits	☐	☐
Does he/she sleep in a room alone?	☐	☐
Does he/she sleep through the night?	☐	☐
If not, does he/she feed during the night?	☐	☐
Does your child…		
11. crow, squeal, babble and imitate sounds	☐	☐
12. show response to his / her name	☐	☐
13. cry when you walk out of the room	☐	☐
14. show displeasure by fussing or crying	☐	☐
15. seem to hear well	☐	☐
16. move all extremities equally well	☐	☐
17. roll over both ways	☐	☐
18. sit unassisted for a brief time	☐	☐
19. try to bat at objects	☐	☐
20. Were there any problems with the second immunizations?	☐	☐
21. Do you have smoke alarms in your house?	☐	☐
22. Is your child exposed to cigarette smoke?	☐	☐
23. Are you getting enough rest?	☐	☐
24. Have you been sad, depressed or crying excessively?	☐	☐
25. Is your child attending day care?	☐	☐
26. Does your child ride in a rear-facing infant safety seat?	☐	☐
27. Do you know infant CPR?	☐	☐

Lead Screen

Does your child…		
1. Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative)	☐	☐
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?	☐	☐

_____ _____
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
☐ Sleep (back, alone)	☐ Solids	☐ Burns-hot water
☐ Crib/Mattress	☐ Vitamins/Fl.	☐ Smoke alarms
☐ Pacifier use	☐ No honey	☐ Hanging cords
☐ TB risk	☐ Start Cup	☐ Electric outlets
☐ Ed. Handouts	☐ No bottle prop	☐ No infant walkers
	☐ No microwave	☐ Sun exposure
		☐ Gun safety