## Interval History:

Has your baby had any major illnesses, ER or Urgent Care trips since your last appointment in the office?  
- No
- Yes

Did your baby pass the hearing test done in the hospital?  
- Yes
- No
- Unsure

Did your baby have a Newborn Screen done in the hospital (test where blood is taken from the heel)?  
- Yes
- No
- Unsure

## Development:

Does your baby regard your face (starting to focus with his/her eyes)?  
- Yes
- No

Does your baby respond to voices or sounds?  
- Yes
- No

Does your baby move both arms and legs equally?  
- Yes
- No

Do you have any concerns about how your baby sees or hears?  
- No
- Yes

Does your baby lift his/her head when lying on his/her tummy?  
- Yes
- No

## Staying Healthy/Safety/Dental Health/Tobacco Exposure:

Does your home have a working smoke detector?  
- Yes
- No

Have you turned your water temperature down to low-warm (less than 120 degrees)?  
- Yes
- No
- N/A

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?  
- Yes
- No

Do you always put your baby to sleep on her/his back?  
- Yes
- No

Do you always stay with your baby when she/he is in the bathtub?  
- Yes
- No

Do you always place your baby in a rear-facing car seat in the back seat?  
- Yes
- No

Is your car seat the right one for the age and size of your baby?  
- Yes
- No

Does your baby spend time with anyone who smokes?  
- No
- Yes
Parental Support:
During the past 2 weeks, how often have you been bothered by the following problems:

- Feeling down, depressed, irritable, or hopeless?
  - [Not at all]  [Several days]  [More than half the days]  [Nearly every day]
- Little interest or pleasure in doing things?
  - [Not at all]  [Several days]  [More than half the days]  [Nearly every day]

Tuberculosis Screening:

- Was your child born in a country with an elevated TB rate?
  - No   Yes
  This includes all countries other than the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

- Has your child visited or lived in a country with an elevated TB rate for one month or more? (Countries other than those listed above)
  - No   Yes

- Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection?
  - No   Yes   Unsure

- Is your child immunosuppressed (currently or planned)?
  - No   Yes
  This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

- How many hours does your baby sleep at night?
  - ___ hours

- How many hours does your baby nap throughout the day?
  - ___ hours

Nutrition/Physical Activity:

- For Breastfeeding: How many minutes of feeding per side?
  - ___ minutes

- For formula/bottle feeding: How many ounces per feeding?
  - ___ oz

If you are giving formula, what brand are you using?

- ______________________

- How often does your baby feed?
  - Every ___ hours

- How many feedings in 24 hours?
  - ___ feedings

- Do you give your baby a bottle of anything except formula or breast milk?
  - No   Yes

- Do you have any concerns about your baby’s feeding?
  - No   Yes
Elimination:
Does your baby have at least 6-8 wet diapers in 24 hours?  Yes  No
Does your baby have bowel movements on a regular basis with
a normal (soft/loose) consistency?  Yes  No

Please list any medications or supplements your baby is taking, including vitamin D:

Who lives in the home with your baby?

Who provides daytime care for your child?

Please list any major family medical issues:

Please list any known Allergies:

Do you have any concerns about your child’s development, or any other concern you would like to discuss with your provider?

Parent or Guardian Signature: ______________________________________________

Date: ____________________________

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PCP’s Signature  Print Name:  Date:

Patient Declined the SHA

Ver.12-12-17

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(04/18)