ABC Pediatrics

One Month Pre-visit Questionnaire

Patient Name_____ Date_____

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Baths: (every other day) (daily)

Formula: _____ Ounces per feeding? ____ Every how many hours? ____

# of stools Daily_____ # of voids Daily_____ # of hours sleeping at ONE time_____

Feeding Concerns:

_____

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things?_____

Have there been any major changes in your family recently other than your baby's birth?

_____

Developmental Milestones (circle all that apply)

☐ Blinks in reaction to light

☐ Responds to sound (startles)

☐ Follows objects past midline

☐ Vocalizes Coos

Any other questions or concerns you would like to discuss?

TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was you child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**

Weight:_____ Height:_____ HC:_____Temp:_____