Boulevard Center Pediatrics, Inc.

"Where your children are the center of our attention."

Well Visit Questionnaire (1 Week of Age – 9 Months of Age)

Patient Name: **Date of Birth:**

Date of Visit: **Parent/Caregiver Name of Person Completing Form:**

General Information:

1. Does your child currently have any medical problems/illness? □ YES □ NO
   If YES, please explain:

2. Does your child have any allergies? □ YES □ NO
   If YES, please explain:

3. Does your child take any medication? □ YES □ NO
   If YES, please explain:

4. Does your child take any vitamins (Ex. D-Vi-Sol): □ YES □ NO
   If YES, please explain:

5. Did your child visit the Emergency Room this year? □ YES □ NO
   If YES, please explain:

6. Did your child have any major injury or fracture in the past? □ YES □ NO
   If YES, please explain:

7. Did your child stay in the hospital for more than 1 day in the past? □ YES □ NO
   If YES, please explain:

8. Has your child had any surgery in the past? □ YES □ NO
   If YES, please explain:

Feeding

1. Please indicate how your child is fed: □Breast Fed □Bottle Fed □Regular Milk □Other Milk_____
2. How often is your child feeding? # of Ounces (Ozs) _____ Every _____hours
3. If using formula, please indicate which one you are using: □Similac Advance □Similac Sensitive □Alimentum □Enfamil Infant □Enfamil Sensitive □Gentlease □Soy □Nutramingen □Other (Please Name)
4. If taking baby food, please indicate what your child is using: □Cereals □Baby Food Stage 1 □Baby Food Stage 2 □Table Food □Eggs/Chicken □Seafood □Peanut Butter/Powder □Other (Explain)

_____

Elimination

1. Does your child have a bowel movement every day? □ YES □ NO
2. Is your child's bowel movement □Soft □Hard

Tuberculosis Screening (If YES for any question below, please ask for TB test.)

1. Have you been abroad for more than 1 month in the past 5 years (outside of the US & Canada?) □ YES □ NO
2. Do you have a close contact of a person known to have TB? □ YES □ NO
3. Do you have a close contact of a person suspected to have TB (HIV+, Drug User or Prison Inmate?) □ YES □ NO

Social History:

Do you live with □Both Parents □Mom Only □Dad Only □Grandparents □Other _____

Mom Birth Year_____ Dad Birth Year_____

Any Smokers in the home? □ YES □ NO

Any Pets in the home? □ YES □ NO

Do you attend Daycare? □ YES □ NO

Please turn page over for additional questions.

Family History (Please Check "√" where applicable)

Relation	Alive (A) or Deceased (D)	Asthma	Allergies	Diabetes	High Cholesterol	High Blood Pressure	Thyroid	Migraine	Other
Mother	□A □D								
Father	□A □D								
Siblings	How many Brothers? How many Sisters?								
Paternal Grandfather	□A □D								
Paternal Grandmother	□A □D								
Maternal Grandfather	□A □D								
Maternal Grandmother	□A □D								

Edinburgh Postnatal Depression Scale (EPDS)

Mother's Name: Mother's Date of Birth

As you are pregnant or recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS,** not just how you feel today.
Here is an example already completed:
I have felt happy: Yes, all the time___ Yes,most of the time X__ No, not very often___ No, not at all___
This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
0___ As much as I always could
1___ Not quite so much now
2___ Definitely not so much now
3___ Not at all

2. I have looked forward with enjoyment to things
0___ As much as I ever did
1___ Rather less than I used to
2___ Definitely less than I used to
3___Hardly at all

3. I have blamed myself unnecessarily when things went wrong
3___Yes, most of the time
2___Yes, some of the time
1___Not very often
0___No, never

4. I have been anxious or worried for no good reason
0___ No, not at all
1___Hardly ever
2___ Yes, sometimes
3___ Yes, very often

5. I have felt scared or panicky for no very good reason
3___ Yes, quite a lot
2___ Yes, sometimes
1___ No, not much
0___No, not at all

6. Things have been getting on top of me
3___Yes, most of the time I haven't been able to cope at all
2___Yes, sometimes I haven't been coping as well as usual
1___No, most of the time I have coped quite well
0___No, I have been coping as well as ever

7. I have been so unhappy that I have difficulty sleeping
3___Yes, most of the time
2___Yes, sometimes
1___ Not very often
0___ No, not at all

8. I have felt sad or miserable
3___Yes, most of the time
2___Yes, quite often
1___Not very often
0___No, not at all

9. I have been so unhappy that I have been crying
3___Yes, most of the time
2___Yes, quite often
1___Only occasionally
0___No, never

10. The thought of harming myself has occurred to me
3___Yes, quite often
2___Sometimes
1___Hardly ever
0___Never

Administered/Reviewed By_____ Date:_____

Parent/Guardian Signature:_____