Northwest PRIMARY CARE

2 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB:_____ Male Female

Physician Signature: _____

Instructions: Please answer the questions about your child below by choosing YES or NO. These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your baby?	◯ NO	◯ YES
Is your baby crying longer than 30 minutes at a time?	◯ NO	◯ YES
Do they have severe nasal stuffiness?	◯ NO	◯ YES
Do you have concerns about skin color or rash?	◯ NO	◯ YES
Are they wheezing?	◯ NO	◯ YES
Feeding/ Nutrition		
Is your child breast feeding well?	◯ YES	◯ NO
How often?		
For how long? (minutes)		
Is your child taking formula well?	◯ YES	◯ NO
How often?		
How many ounces?		
Which formula?		
Are you feeding your baby anything other than breast milk or formula?	◯ NO	◯ YES
Is your baby taking a vitamin supplement?	◯ YES	◯ NO
Elimination		
Are they having problems with bowel movements (pooping)?	◯ NO	◯ YES
Are they urinating (peeing) well?	◯ YES	◯ NO
Sleep		
Are they sleeping five or more hours at a time?	◯ YES	◯ NO
Do you have questions about sleep habits?	◯ NO	◯ YES
Social Stressors		
Has either parent been sad or crying a lot? Feeling down, depressed, or hopeless?	◯ NO	◯ YES
Are the siblings adjusting well to the newborn?	◯ YES	◯ NO
Are you having family stress?	◯ NO	◯ YES
Do you ever worry your family will go hungry?	◯ NO	◯ YES
Do you have daycare concerns?	◯ NO	◯ YES

2 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: _____ DOB:_____

Development		
Does your baby smile at the sound of parent's voice?	◯ **YES**	◯ **NO**
Does your baby make cooing noises?	◯ **YES**	◯ **NO**
Does your baby watch as parent walks across the room?	◯ **YES**	◯ **NO**
Does your baby raise their head and chest when lying on tummy?	◯ **YES**	◯ **NO**
Does your baby briefly hold objects when placed in their hand?	◯ **YES**	◯ **NO**
Safety		
Is your baby swaddled when sleeping?	◯ **NO**	◯ **YES**
Does your baby sleep on his/her back?	◯ **YES**	◯ **NO**
Does your baby sleep in a bassinet or crib, not parents' bed?	◯ **YES**	◯ **NO**
Do you always keep a hand on baby when placed above the floor?	◯ **YES**	◯ **NO**
Does your baby wear any jewelry including necklaces?	◯ **NO**	◯ **YES**
Do you hold or carry hot liquids around the baby?	◯ **NO**	◯ **YES**
Do you keep plastic bags and latex balloons away from your baby?	◯ **YES**	◯ **NO**
Does your baby ride in a rear facing safety seat, in the back seat?	◯ **YES**	◯ **NO**
Is your baby exposed to anyone who smokes?	◯ **NO**	◯ **YES**
Are there working smoke detectors and carbon monoxide detectors in the home?	◯ **YES**	◯ **NO**
Tuberculosis		
Has a family member or contact had tuberculosis disease?	◯ **NO**	◯ **YES**
Has a family member or contact had a positive TB skin test (PPD)?	◯ **NO**	◯ **YES**
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	◯ **NO**	◯ **YES**
Has your baby traveled to a high-risk country for more than a week?	◯ **NO**	◯ **YES**