Maryland Healthy Kids Program
Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

		Who?
Allergies (List) _____	No ☐ Yes ☐	_____
_____		
Asthma	No ☐ Yes ☐	_____
TB/Lung Disease	No ☐ Yes ☐	_____
HIV/AIDS	No ☐ Yes ☐	_____
Suicide Attempts	No ☐ Yes ☐	_____
Heart Disease	No ☐ Yes ☐	_____
High Blood Pressure/Stroke	No ☐ Yes ☐	_____
High Cholesterol	No ☐ Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐ Yes ☐	_____
Diabetes	No ☐ Yes ☐	_____
Seizures	No ☐ Yes ☐	_____
Mental Illness	No ☐ Yes ☐	_____
Cancer	No ☐ Yes ☐	_____
Birth Defects	No ☐ Yes ☐	_____
Hearing Loss	No ☐ Yes ☐	_____
Speech Problems	No ☐ Yes ☐	_____
Kidney Disease	No ☐ Yes ☐	_____
Alcohol/Drug Abuse	No ☐ Yes ☐	_____
Hepatitis/Liver Disease		
Thyroid Disease	No ☐ Yes ☐	_____
Learning Problems/Attention	No ☐ Yes ☐	_____
Deficit Disorder	No ☐ Yes ☐	_____
Family Violence	No ☐ Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review:

NUTRITION QUESTIONNAIRE FOR INFANTS

1. How would you describe feeding time with your baby?
(Check all that apply.)

- ☐ Always pleasant
- ☐ Usually pleasant
- ☐ Sometimes pleasant
- ☐ Never pleasant

2. How do you know when your baby is hungry or has had enough to eat?

3 What type of milk do you feed your baby and how often?
(Check all that apply.)

- ☐ Iron-fortified infant formula
- ☐ Evaporated milk
- ☐ Whole milk
- ☐ Reduced-fat (2%) milk
- ☐ Low-fat (1%) milk
- ☐ Fat-free (skim) milk
- ☐ Goat's milk
- ☐ Soymilk

4. What types of things can your baby do?
(Check all that apply.)

- ☐ Open mouth for breast or bottle
- ☐ Drink liquids
- ☐ Follow objects and sounds with eyes
- ☐ Put hand in mouth
- ☐ Sit with support
- ☐ Bring objects to mouth and bite them
- ☐ Hold bottle without support
- ☐ Drink from a cup that is held

5. Does your baby eat solid foods? If yes, which ones?

6. Does your baby drink juice? If yes, how much?

7. Does your baby take a bottle to bed at night or carry a bottle around during the day?

8. Do you add honey to your baby's bottle or dip your baby's pacifier in honey?

9. What is the source of the water your baby drinks? Sources include public, well, commercially bottled, and home system-processed water.

10. Do you have a working stove, oven, and refrigerator where you live?

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. What concerns or questions do you have about feeding your baby or how your baby is growing? Do you have any concerns or questions about your baby's weight?

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has your child ever lived outside the United States or recently arrived from a foreign country?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Does your family use products from other countries such as health remedies, traditional remedies, spices, cosmetics or other products canned or packaged outside of the United States? Or store or serve food in leaded crystal, pottery or pewter? **Examples**: Glazed pottery, Greta, Azarcon (Rueda, Coral, Liga), Litargirio, Surma, Kohl (Al kohl), Pay-loo-ah, Ayurvedic medicine, Ghassard).	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Tuberculosis Risk Assessment: *(The assessment must be completed at 1, 6 and 12 months, and then annually starting at 36 months.)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child been exposed to anyone with a case of TB **or** a positive tuberculin skin test, **or** received a tuberculosis vaccination?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: _____ **Birth Date:** _____

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

ASQ-3 Ages & Stages Questionnaires®

1 month 0 days through 2 months 30 days

2 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Baby's information

Baby's first name:

Middle initial:

Baby's last name:

Baby's date of birth: M M D D Y Y Y Y

If baby was born 3 or more weeks prematurely, # of weeks premature:

Baby's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to baby: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Baby ID #:

Age at administration, in months and days: M M D D

Program ID #:

If premature, adjusted age, in months and days: M M D D

Program name:

E101020100

ASQ-3™

2 Month Questionnaire

1 month 0 days through 2 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by _____.

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	○	○	○	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	○	○	○	___
3. When you speak to your baby, does she make sounds back to you?	○	○	○	___
4. Does your baby smile when you talk to him?	○	○	○	___
5. Does your baby chuckle softly?	○	○	○	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	○	○	○	___
2. When your baby is on her tummy, does she turn her head to the side?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	○	○	○	___
4. When your baby is on her back, does she kick her legs?	○	○	○	___
5. While your baby is on his back, does he move his head from side to side?	○	○	○	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	○	○	○	___

GROSS MOTOR TOTAL ___

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FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Is your baby's hand usually tightly closed when he is awake? (*If your baby used to do this but no longer does, mark "yes."*)	○	○	○	___
2. Does your baby grasp your finger if you touch the palm of her hand? 	○	○	○	___
3. When you put a toy in his hand, does your baby hold it in his hand briefly? 	○	○	○	___
4. Does your baby touch her face with her hands?	○	○	○	___
5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? 	○	○	○	___ *
6. Does your baby grab or scratch at her clothes?	○	○	○	___

FINE MOTOR TOTAL ___

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. Does your baby look at objects that are 8–10 inches away?	○	○	○	___
2. When you move around, does your baby follow you with his eyes?	○	○	○	___
3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head?	○	○	○	___
4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes?	○	○	○	___
5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her?	○	○	○	___
6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes try to suck, even when she's not feeding?	○	○	○	___
2. Does your baby cry when he is hungry, wet, tired, or wants to be held?	○	○	○	___
3. Does your baby smile at you?	○	○	○	___
4. When you smile at your baby, does she smile back?	○	○	○	___
5. Does your baby watch his hands? 	○	○	○	___
6. When your baby sees the breast or bottle, does she seem to know she is about to be fed?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain: ○ YES ○ NO

2. Does your baby move both hands and both legs equally well? If no, explain: ○ YES ○ NO

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: ○ YES ○ NO

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OVERALL *(continued)*

4. Has your baby had any medical problems? If yes, explain: ○ YES ○ NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain: ○ YES ○ NO

6. Does anything about your baby worry you? If yes, explain: ○ YES ○ NO

ASQ-3

2 Month ASQ-3 Information Summary

1 months 0 days through 2 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	22.77		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Gross Motor	41.84		●	●	●	●	●	●	●	●	●	◯	◯	◯	◯
Fine Motor	30.16		●	●	●	●	●	●	●	◯	◯	◯	◯	◯	◯
Problem Solving	24.62		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Personal-Social	33.71		●	●	●	●	●	●	●	◯	◯	◯	◯	◯	◯

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Passed newborn hearing screening test? Yes **NO**
   Comments:

2. Moves both hands and both legs equally well? Yes **NO**
   Comments:

3. Family history of hearing impairment? **YES** No
   Comments:

4. Any medical problems? **YES** No
   Comments:

5. Concerns about behavior? **YES** No
   Comments:

6. Other concerns? **YES** No
   Comments:

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the ▭ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): _____.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101020600

Activities for Infants 1- 4 Months Old

ASQ-3™

Talk softly to your baby when feeding him, changing his diapers, and holding him. He may not understand every word, but he will know your voice and be comforted by it.	When you see your baby responding to your voice, praise and cuddle her. Talk back to her and see if she responds again.	Take turns with your baby when he makes cooing and gurgling sounds. Have a "conversation" back and forth with simple sounds that he can make.	Sing to your baby (even if you don't do it well). Repetition of songs and lullabies helps your baby to learn and listen.	With your baby securely in your arms or in a front pack, gently swing and sway to music that you are singing or playing on the radio.
Place a shatterproof mirror close to your baby where she can see it. Start talking, and tap the mirror to get her to look. The mirror will provide visual stimulation. Eventually your baby will understand her reflection.	Rock your baby gently in your arms and sing "Rock-a-bye Baby" or another lullaby. Sing your lullaby and swing your baby to the gentle rhythm.	Put a puppet or small sock on your finger. Say your baby's name while moving the puppet or sock up and down. See whether he follows the movement. Now move your finger in a circle. Each time your baby is able to follow the puppet, try a new movement.	With your baby on her back, hold a brightly colored stuffed animal above her head, in her line of vision. See if she watches the stuffed animal as you move it slowly back and forth.	Make sure your baby is positioned so that you can touch his feet. Gently play with his toes and feet, tickling lightly. Add the "This Little Piggy Went to Market" rhyme, touching a different toe with each verse.
Rest your baby, tummy down, on your arm, with your hand on her chest. Use your other hand to secure your baby—support her head and neck. Gently swing her back and forth. As she gets older, walk around to give her different views.	Hold your baby in your lap and softly shake a rattle on one side of his head, then the other side. Shake slowly at first, then faster. Your baby will search for the noise with his eyes.	Place your baby on her tummy with head to one side, on a blanket/towel on carpeted floor. Lie next to her to provide encouragement. Until she has the strength, have her spend equal time facing left and right. Make "tummy time" a little longer each day. Closely watch your baby in case she rests her face on the floor, which could restrict breathing. As her strength grows, she will be able to lift her head and push up on her arms, leading to rolling and crawling.	Lay your baby on his back and touch his arms and legs in different places. Make a "whooping" sound with each touch. Your baby may smile and anticipate the next touch by watching your hand. When you make each sound, you can also name the part of the body you touch.	In nice weather, take your baby on a nature walk through a park or neighborhood. Talk about everything you see. Even though she might not understand everything, she will like being outside and hearing your voice.
Read simple books to your baby. Even if he does not understand the story, he will enjoy being close and listening to you read.	With white paper and a black marker, create several easy-to-recognize images on each piece of paper. Start with simple patterns (diagonal stripes, bull's eyes, checkerboards, triangles). Place the pictures so that your baby can see them (8"–12" inches from her face). Tape these pictures next to her car seat or crib.	Lay your baby on his back on a soft, flat surface such as a bed or a blanket. Gently tap or rub your baby's hands and fingers while singing "Pat-a-Cake" or another nursery rhyme.	Gently shake a rattle or another baby toy that makes a noise. Put it in your baby's hand. See if she takes it, even for a brief moment.	Hold your baby closely, or lay him down on a soft, flat surface. Be close enough (8"–12") so that he can see you. Face to face, start with small movements (stick out your tongue, open your mouth with a wide grin). If you are patient, your baby may try to imitate you. As he gets older, you can try larger body movements with your head, hands, and arms. You can also try to imitate your baby.