

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		PSYCHOSOCIAL HISTORY																																																																																																																																																														
Name of Hospital: _____ Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Alcohol/Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/> Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/> Describe: _____ Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Birth Weight _____ Discharge Weight _____ Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> Date of Hepatitis B immunization: _____ Newborn Hearing Screen? No <input type="checkbox"/> Yes <input type="checkbox"/>		Who lives in household? _____ _____ How many? _____ <input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter? Who cares for child? _____ Date of Birth? Mother _____ Father _____ Are parents working? Mother No <input type="checkbox"/> Yes <input type="checkbox"/> Father No <input type="checkbox"/> Yes <input type="checkbox"/> Foster Care? _____ Dates: _____ Other Languages? _____																																																																																																																																																														
FAMILY HISTORY		MEDICAL HISTORY																																																																																																																																																														
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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?

NUTRITION QUESTIONNAIRE FOR INFANTS

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)

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	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	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	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	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	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	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	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	Date	Date
1. Has your child been exposed to anyone with a case of TB <u>or</u> a positive tuberculin skin test, <u>or</u> received a tuberculosis vaccination?	Y / N	Y / N	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	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	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	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	Y / N	Y / N

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

Patient Name: _____

Birth Date: _____



Ages & Stages Questionnaires®

4 Month Questionnaire

3 months 0 days through 4 months 30 days



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:



4 Month Questionnaire

3 months 0 days
through 4 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 chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. After you have been out of sight, does your baby smile or get excited when he sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby stop crying when she hears a voice other than yours?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby laugh?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby make sounds when looking at toys or people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her tummy, does she hold her head straight up, looking around? <i>(She can rest on her arms while doing this.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 5. When you hold him in a sitting position, does your baby hold his head steady? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| | | | | GROSS MOTOR TOTAL ___ |



FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|----------------------|
| 1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you put a toy in her hand, does your baby wave it about, at least briefly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby grab or scratch at his clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| | | | | FINE MOTOR TOTAL ___ |



PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|-----------------------|-----------------------|-----------------------|-----|
| 1. 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 his eyes, sometimes turning his head? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. 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 her eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you put a toy in her hand, does your baby look at it? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. When you put a toy in his hand, does your baby put the toy in his mouth? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

PROBLEM SOLVING (continued)

6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

1. Does your baby watch his hands?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. When your baby has her hands together, does she play with her fingers?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. Before you smile or talk to your baby, does he smile when he sees you nearby?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. When in front of a large mirror, does your baby smile or coo at herself?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

PERSONAL-SOCIAL TOTAL ___

OVERALL

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

1. Does your baby use both hands and both legs equally well? If no, explain:

YES NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain:

YES NO

OVERALL (continued)

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

 YES NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

 YES NO

5. Do you have concerns about your baby's vision? If yes, explain:

 YES NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

 YES NO

7. Do you have any concerns about your baby's behavior? If yes, explain:

 YES NO

8. Does anything about your baby worry you? If yes, explain:

 YES NO



4 Month ASQ-3 Information Summary

3 months 0 days through
4 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	34.60		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	38.41		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	29.62		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	34.98		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	33.16		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. Other concerns?
Comments: | YES | No |

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						

Activities for Infants 4 - 8 Months Old



<p>Put a windup toy beside or behind your baby. Watch to see if your baby searches for the sound.</p>	<p>Give your baby a spoon to grasp and chew on. It's easy to hold and feels good in the mouth. It's also great for banging, swiping, and dropping.</p>	<p>While sitting on the floor, place your baby in a sitting position inside your legs. Use your legs and chest to provide only as much support as your baby needs. This allows you to play with your baby while encouraging independent sitting.</p>	<p>Gently rub your baby with a soft cloth, a paper towel, or nylon. Talk about how things feel (soft, rough, slippery). Lotion feels good, too.</p>	<p>Let your baby see herself in a mirror. Place an unbreakable mirror on the side of your baby's crib or changing table so that she can watch. Look in the mirror with your baby, too. Smile and wave at your baby.</p>
<p>Common household items such as measuring spoons and measuring cups make toys with interesting sounds and shapes. Gently dangle and shake a set of measuring spoons or measuring cups where your baby can reach or kick at them. Let your baby hold them to explore and shake, too.</p>	<p>Play voice games. Talk with a high or low voice. Click your tongue. Whisper. Take turns with your baby. Repeat any sounds made by him. Place your baby so that you are face to face—your baby will watch as you make sounds.</p>	<p>Fill a small plastic bottle (empty medicine bottle with child-proof cap) with beans or rice. Let your baby shake it to make noise.</p>	<p>Make another shaker using bells. Encourage your baby to hold one in each hand and shake them both. Watch to see if your baby likes one sound better than another.</p>	<p>Place your baby on her tummy with favorite toys or objects around but just slightly out of reach. Encourage her to reach out for toys and move toward them.</p>
<p>Fill an empty tissue box with strips of paper. Your baby will love pulling them out. (Do not use colored newsprint or magazines; they are toxic. Never use plastic bags or wrap.)</p>	<p>Safely attach a favorite toy to a side of your baby's crib, swing, or cradle chair for him to reach and grasp. Change toys frequently to give him new things to see and do.</p>	<p>Place your baby in a chair or car seat, or prop her up with pillows. Bounce and play with a flowing scarf or a large bouncing ball. Move it slowly up, then down or to the side, so that your baby can follow movement with her eyes.</p>	<p>With your baby lying on his back, place a toy within sight but out of reach, or move a toy across your baby's visual range. Encourage him to roll to get the toy.</p>	<p>Play Peekaboo with hands, cloth, or a diaper. Put the cloth over your face first. Then let your baby hide. Pull the cloth off if your baby can't. Encourage her to play. Take turns.</p>
<p>Place your baby in a chair or car seat to watch everyday activities. Tell your baby what you are doing. Let your baby see, hear, and touch common objects. You can give your baby attention while getting things done.</p>	<p>Place your baby on your knee facing you. Bounce him to the rhythm of a nursery rhyme. Sing and rock with the rhythm. Help your baby bring his hands together to clap to the rhythm.</p>	<p>Your baby will like to throw toys to the floor. Take a little time to play this "go and fetch" game. It helps your baby to learn to release objects. Give baby a box or pan to practice dropping toys into.</p>	<p>Once your baby starts rolling or crawling on her tummy, play "come and get me." Let your baby move, then chase after her and hug her when you catch her.</p>	<p>Place your baby facing you. Your baby can watch you change facial expressions (big smile, poking out tongue, widening eyes, raising eyebrows, puffing or blowing). Give your baby a turn. Do what your baby does.</p>