

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	
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had: Allergies (List) _____ No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Who? Asthma No <input type="checkbox"/> Yes <input type="checkbox"/> _____ TB/Lung Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____ HIV/AIDS No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Suicide Attempts No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Heart Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____ High Blood Pressure/Stroke No <input type="checkbox"/> Yes <input type="checkbox"/> _____ High Cholesterol No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Blood Disorders/Sickle Cell No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Diabetes No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Seizures No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Mental Illness No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Cancer No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Birth Defects No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Hearing Loss No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Speech Problems No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Kidney Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Alcohol/Drug Abuse No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Hepatitis/Liver Disease Thyroid Disease No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Learning Problems/Attention Deficit Disorder No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Family Violence No <input type="checkbox"/> Yes <input type="checkbox"/> _____ Other: _____ _____		Has your child ever had: Allergies (List) _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Asthma No <input type="checkbox"/> Yes <input type="checkbox"/> Chicken Pox (Year) _____ No <input type="checkbox"/> Yes <input type="checkbox"/> Frequent Ear Infections No <input type="checkbox"/> Yes <input type="checkbox"/> Vision/Hearing Problems No <input type="checkbox"/> Yes <input type="checkbox"/> Skin Problems/Eczema No <input type="checkbox"/> Yes <input type="checkbox"/> TB/Lung Disease No <input type="checkbox"/> Yes <input type="checkbox"/> Seizures/Epilepsy No <input type="checkbox"/> Yes <input type="checkbox"/> High Blood Pressure No <input type="checkbox"/> Yes <input type="checkbox"/> Heart Defects/Disease No <input type="checkbox"/> Yes <input type="checkbox"/> Liver Disease/Hepatitis No <input type="checkbox"/> Yes <input type="checkbox"/> Diabetes No <input type="checkbox"/> Yes <input type="checkbox"/> Kidney Disease/Bladder Infections No <input type="checkbox"/> Yes <input type="checkbox"/> Physical or Learning Disabilities No <input type="checkbox"/> Yes <input type="checkbox"/> Bleeding Disorders/Hemophilia No <input type="checkbox"/> Yes <input type="checkbox"/> Sexually Transmitted Diseases No <input type="checkbox"/> Yes <input type="checkbox"/> Emotional or Behavioral Problems No <input type="checkbox"/> Yes <input type="checkbox"/> Depression/Suicidal Thoughts No <input type="checkbox"/> Yes <input type="checkbox"/> Hospitalizations/Surgeries No <input type="checkbox"/> Yes <input type="checkbox"/> Physical/Emotional/ Sexual Abuse No <input type="checkbox"/> Yes <input type="checkbox"/> Bone or Joint Injuries No <input type="checkbox"/> Yes <input type="checkbox"/> Obesity/Eating Disorders No <input type="checkbox"/> Yes <input type="checkbox"/> Other: _____ No <input type="checkbox"/> Yes <input type="checkbox"/> _____ _____ 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?

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	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	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	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	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	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	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-100-ah, Ayurvedic medicine, Ghassard).	Y / N	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: _____

<https://mmpc.dhmh.maryland.gov/psdft/Pages/Home.aspx>

Updated 8/18



Ages & Stages Questionnaires®

6 Month Questionnaire

5 months 0 days through 6 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:



6 Month Questionnaire

5 months 0 days
through 6 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 make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<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 your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you put your baby on the floor, does she lean on her hands while sitting? (If she already sits up straight without leaning on her hands, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

5. If you hold both hands just to balance your baby, does he support his own weight while standing?



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

6. Does your baby get into a crawling position by getting up on her hands and knees?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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GROSS MOTOR TOTAL ___

FINE MOTOR

1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?

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

2. Does your baby reach for or grasp a toy using both hands at once?

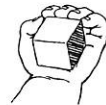
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)*



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? *(If he already picks up the crumb or Cheerio, mark "yes" for this item.)*



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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6. Does your baby pick up a small toy with only one hand?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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FINE MOTOR TOTAL ___

PROBLEM SOLVING

1. When a toy is in front of your baby, does she reach for it with both hands?

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




2. When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*

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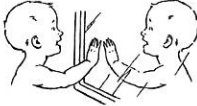



3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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PROBLEM SOLVING (continued)

	YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. Does your baby pass a toy back and forth from one hand to the other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby play by banging a toy up and down on the floor or table?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
	PROBLEM SOLVING TOTAL			___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. Does your baby act differently toward strangers than he does with you and other familiar people? (Reactions to strangers may include staring, frowning, withdrawing, or crying.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. While lying on her back, does your baby play by grabbing her foot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. When in front of a large mirror, does your baby reach out to pat the mirror?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. While your baby is on his back, does he put his foot in his mouth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby try to get a toy that is out of reach? (She may roll, pivot on her tummy, or crawl to get it.)	<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

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



6 Month ASQ-3 Information Summary

5 months 0 days through
6 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	29.65		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	22.25		●	●	●	●	●	●	○	○	○	○	○	○	○
Fine Motor	25.14		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	27.72		●	●	●	●	●	●	○	○	○	○	○	○	○
Personal-Social	25.34		●	●	●	●	●	●	○	○	○	○	○	○	○

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>