1 Week Visit Questionnaire

Infant's Last Name: _________________ **First Name:** ________________ **Birthdate:**____________ **Today's Date:**_____________

General:	CIRCLE		(If yes, explain below)
Do you have any specific concerns for today's visit?	No	Yes*	
Is your infant taking any prescription medications?	No	Yes*	
Are your infant's vaccines covered by your insurance plan?	No	Yes	
Family Medical:			
Do the parents have any significant medical issues that we should be aware of?	No	Yes*	
Have there been any other significant family medical issues recently?	No	Yes*	
Social:			
Are the biological parents married?	No	Yes	
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes*	
Are there any smokers in the household? (If yes, please indicate who)	No	Yes*	
Do you have any concerns regarding domestic abuse or child abuse in your household?	No	Yes*	
Symptom Review:			
Has the infant had any fever (over 100.4) or significant cough in the last 3 days?	No	Yes*	
Is the infant overly irritable?	No	Yes*	
Is the infant overly sleepy such that he/she does not wake for feedings regularly?	No	Yes*	
Is there any eye redness or discharge?	No	Yes*	
Did your infant FAIL the infant hearing screen?	No	Yes*	
Is the infant having any significant breathing problems that you are concerned about?	No	Yes*	
Does your infant have any forceful, projectile vomiting?	No	Yes*	
Do you have any concerns regarding your infant's voiding/urinary habits?	No	Yes*	
Did your infant have a problem with prolonged bleeding after circumcision (if applicable)?	No	Yes*	
Does your infant have a weakness or failure to use any of his/her arms or legs?	No	Yes*	
Does your infant prefer to keep his head to one side most of the time?	No	Yes*	
Does your infant have any unusual rashes that you are concerned about?	No	Yes*	

*Explain 'YES" Answers: ____

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