Name FMP/SSN last four: DOB:

Email Address : Contact Phone Number:

4 - 11 MONTH VISIT

Do you have any specific concerns today? _____

_____

_____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions	Surgeries/ Hospitalizations	Dates	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies **Asthma** **Premie** **Overweight** **Chronic ear infections** **Other: (reflux)**	Example circumcision		**Allergies** **Asthma** **Diabetes** **Heart Disease** **Obesity**	**(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):** ❑ Infant Multivitamin 1 ml per day

Any hospitalizations, specialty care or ER visits since last appointment? ❑Yes ❑No Please specify _____

Circle if anyone in the family has had:

Genetic or Metabolic Disease / Birth Defects / Kidney Disease / Deafness < 5 years old/
Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Please list any known **allergies** your child has (drug, food, latex) _____

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? ❑ Yes ❑ No

Is the child's sponsor currently deployed? ❑Yes ❑ No Is this visit **deployment** related? ❑ Yes ❑ No

Are your child's immunizations up to date? ❑ Yes ❑ No ❑ Unsure

Who does your child live with? _____

Does your child attend daycare? ❑ Yes ❑ No

Does anyone in the family smoke? ❑ Yes ❑ No

Do you feel safe at home? ❑ Yes ❑ No

What is your preferred method for learning: ❑ Verbal ❑ Written ❑ Visual ❑ Other: _____

Preferred language: ❑ English ❑ Other: _____

Please See Reverse Side

RECORDS MAINTAINED AT: ▶		
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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Are there cultural or religious considerations that affect your child's healthcare? ❑ Yes ❑ No _____

Ethnic Origin ❑Filipino ❑Hispanic ❑ Asian/Pacific Islander ❑Southeast Asian ❑ Other ❑ Unknown ❑ Decline to Respond

Race ❑ Asian/Pacific Islander ❑ African American ❑ Caucasian ❑ Western Indian ❑ Other ❑ Unknown ❑ Decline to Respond

Birth History: (if not completed before)

weeks pregnant at delivery? _____

Type of Delivery (check all that apply): ❑ Vaginal ❑ Forceps ❑ Vacuum-assisted ❑ C-section ❑ Breech

Complications at birth? _____

Prenatal complications? ❑ Yes ❑ No
List:_____

Group B Strep positive? ❑ Yes ❑ No ❑ Don't Know

Baby's hearing screen normal? ❑ Yes ❑ No ❑ Not performed

Breastfeeding? ❑ Yes ❑ No How often? _____ Minutes per breast?_____ Concerns?_____

Bottle feeding? ❑ Yes ❑ No Brand? _____ Ounces per feed? _____ Ounces per day? _____

Cereal? ❑ Yes ❑ No How many times per day? _____ Solid foods? ❑ Yes ❑ No How many times per day? _____

Number of wet diapers per day? _____ Stools per day? _____

Circle if you have any concerns about the following: Bowel movements / Constipation / Sleep problems

Does either parent have: Little interest or pleasure in doing things? Feeling down, depressed, or hopeless? ❑ Yes ❑ No

In the past week, has your child had:

Fever	Yes/No	Duration?_____	Wheezing	Yes/No	Duration?_____
Congestion	Yes/No	Duration?_____	Vomiting	Yes/No	Duration?_____
Runny nose	Yes/No	Duration?_____	Diarrhea	Yes/No	Duration?_____
Pulling at ears	Yes/No	Duration?_____	Appetite Less	Yes/No	Duration?_____
Eye discharge	Yes/No	Duration?_____	Rash	Yes/No	Duration?_____
Cough	Yes/No	Duration?_____	Other (describe)_____		

If Ages & Stages Questionnaire NOT completed today, check all the following that apply to your child:

4 MONTH	6 MONTH	9 MONTH
❑ Turns toward voices	❑ Babbles	❑ Sits without help
❑ Head steady when sitting	❑ Responds to name	❑ Crawls
❑ Bears weight on legs	❑ Passes toys from hand to hand	❑ Pulls to a stand
❑ Pushes chest off surface when on tummy	❑ Sits without help if propped	❑ Feeds self with fingers
	❑ Rolls from back to front	❑ Grabs small objects with hands
❑ Brings hands together	❑ Rolls from front to back	❑ Plays Peek-a-Boo
❑ Reaches for objects		❑ Shy with strangers
❑ Laughs		❑ Remembers an object is there if covered

PLEASE GIVE THIS FORM TO YOUR PROVIDER'S ASSISTANT