BIRTH & BEYOND PEDIATRICS P.C.

DEVELOPMENTAL SCREENING
15 MONTHS

Patient Name: _____ Date of Birth: ____ /____ /____

Please tell me any concerns, questions, problems you have about the way your child is behaving, developing/growth and/or learning:

_____

_____

DEVELOPMENTAL QUESTIONS AND OBSERVATIONS

☐ YES ☐ NO My toddler scribbles.

☐ YES ☐ NO My toddler is interested in people, places and things.

☐ YES ☐ NO My toddler walks.

☐ YES ☐ NO My toddler feeds self with fingers/spoon and drinks from a cup.

☐ YES ☐ NO My toddler can stack 2-3 blocks.

☐ YES ☐ NO My toddler says 2-3 words.

DEVELOPMENTAL MILESTONES

TODDLER DEVELOPMENT

☐ YES ☐ NO Understands simple commands

☐ YES ☐ NO Walks without support

☐ YES ☐ NO Indicates wants by pointing or gestures

☐ YES ☐ NO Is able to transition from one activity to another throughout the day

☐ YES ☐ NO Appears to have a secure and attached relationship with parent

☐ YES ☐ NO Stoops and recovers

☐ YES ☐ NO Tries to undress self

TUBERCULOSIS

Was your child born in a country at high risk for tuberculosis *(countries other than the United States, Canada, Australia, New Zealand or Western Europe)*? ☐ YES ☐ NO

Has your child traveled *(had contact with resident populations)* for longer than one (1) week to a country at high risk for tuberculosis? ☐ YES ☐ NO

Has a family member or contact had tuberculosis or a positive tuberculin skins test? ☐ YES ☐ NO

Is your child infected with HIV? ☐ YES ☐ NO

Additional comments:

_____

_____

Signature: _____ Date: _____ Relationship to Patient: _____

This screening form was adapted in part by the Ohio Medicaid managed care plans; Ohio Department of Jobs and Family Services, American Academy of Pediatrics, Bright Futures 2010.

BIRTH & BEYOND
PEDIATRICS P.C.

ANEMIA RISK QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____ /_____ /_____

1. Has your child ever been diagnosed with iron deficiency anemia?

☐ Yes ☐ No

2. Do you ever have trouble getting food on the table?

☐ Yes ☐ No

3. If your child is under the age of 6 months, was your child born premature?

☐ Yes ☐ No

4. If your child is under the age of 6 months, did your child have a low birth weight?

☐ Yes ☐ No

5. Is your child on a strict vegetarian diet?

☐ Yes ☐ No

6. Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

☐ Yes ☐ No

7. If your child is under the age of 6 months, is your child drinking anything besides breastmilk or iron-fortified formula?

☐ Yes ☐ No

BIRTH & BEYOND
PEDIATRICS P.C.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____ /_____ /_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Check boxes to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL**: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

BIRTH & BEYOND PEDIATRICS P.C.

SEXUAL ACTIVITY QUESTIONS
13 YEARS & UP

WARNING: ***The following questions are very explicit and required by some insurance companies. If you do not feel comfortable answering these questions, please select defer.***

Date of Birth: ____ /____ /____ ☐ Male ☐ Female

Patient Name: _____

FEMALES ONLY

☐ YES ☐ NO ☐ DEFER Do you have excessive menstrual bleeding or other blood loss?

☐ YES ☐ NO ☐ DEFER Does your period last more than 5 days?

☐ YES ☐ NO ☐ DEFER Have you ever had sex (including intercourse or oral sex)?

☐ YES ☐ NO ☐ DEFER Have any of your past or current sex partners been infected with HIV, bisexual or injection drug users?

☐ YES ☐ NO ☐ DEFER Have you ever been treated for a sexually transmitted infection?

☐ YES ☐ NO ☐ DEFER Are you having unprotected sex with multiple partners?

☐ YES ☐ NO ☐ DEFER Do you trade sex for money or drugs or have sex partners who do?

☐ YES ☐ NO ☐ DEFER Was your first time having sexual intercourse more than 3 years ago?

☐ YES ☐ NO ☐ DEFER Have you been sexually active without using birth control?

☐ YES ☐ NO ☐ DEFER Have you been sexually active and had a late or missed period within the last 2 months?

MALES ONLY

☐ YES ☐ NO ☐ DEFER Have you ever had sex (including intercourse or oral sex)?

☐ YES ☐ NO ☐ DEFER Have you ever been treated for a sexually transmitted infection?

☐ YES ☐ NO ☐ DEFER Are you having unprotected sex with multiple partners?

☐ YES ☐ NO ☐ DEFER Have you ever had sex with other men?

☐ YES ☐ NO ☐ DEFER Do you trade sex for money or drugs or have sex partners who do?

☐ YES ☐ NO ☐ DEFER Are you having unprotected sex with multiple partners?

☐ YES ☐ NO ☐ DEFER Have any of your past or present sex partners been infected with HIV, bisexual or injection drug users?

Additional comments:

_____

_____

Signature: _____ Date: _____ Relationship to Patient: _____

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