HOLYOKE PEDIATRIC ASSOCIATES, LLP

# Pre-Visit Questionnaire
# 2 Month Visit

## What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today? _____

_____

_____

_____

## Questions about your baby.

Vision  Do you have concerns about how your child sees?  ❑ Yes ❑ No ❑ Unsure

Have any of your child's relatives developed new medical problems since your last visit?

❑ Yes ❑ No ❑ Unsure  If yes, please explain: _____

_____

Other than your baby's birth, have there been any major changes in your family lately? ❑ No ❑ Yes

❑ *Move* ❑ *Separation* ❑ *Divorce* ❑ *Death in the family* ❑ *Job change* ❑ *Other* _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things ❑ Not at all ❑ Several Days ❑ More than half the days ❑ Nearly every day

2. Feeling down, depressed, or hopeless ❑ Not at all ❑ Several Days ❑ More than half the days ❑ Nearly every day

* Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ❑ Yes ❑ No

Does your child have any special health care needs? ❑ Yes ❑ No If yes, please explain: _____

_____

* List your child's current medications and doses: Include any herbs, vitamins or supplements. _____

_____

_____

* What is the best way to contact you (please circle): home phone / cell phone / work phone: _____

* Would you like to share your email address? _____