



Review of Systems

Please place a check mark next to any of the following symptoms that apply to the patient’s current health.

General:

- Fever _____
- Fatigue _____
- Weight Loss _____

Eyes:

- Blurred Vision _____
- Eye Pain _____
- Glasses _____

Ear/Nose/Throat:

- Ear Pain _____
- Decreased Hearing _____
- Nosebleeds _____
- Nasal Congestion _____
- Runny Nose _____
- Sore Throat _____
- Hoarseness _____
- Difficulty Swallowing _____

Respiratory:

- Cough _____
- Wheezing _____
- Shortness of Breath _____

Cardiovascular:

- Heart Murmur _____
- Chest Pain _____
- Irregular Heart Beat _____
- Blood Pressure Problem _____

Gastrointestinal:

- Abdominal Pain _____
- Nausea _____
- Vomiting _____
- Diarrhea _____
- Constipation _____
- Blood in Stool _____
- Heartburn _____

Genitourinary:

- Pain with Urination _____
- Blood in Urine _____
- Frequent Urination _____
- Bedwetting _____

Endocrine:

- Hair Loss _____
- Cold/Heat Intolerance _____
- Abnormal Period _____

Skin:

- Rash _____
- Acne _____

Hematology:

- Easy Bleeding _____
- Easy Bruising _____
- Anemia _____

Musculoskeletal:

- Bone Pain _____
- Back Pain _____
- Swollen Joint _____
- Muscle Pain _____

Neurological:

- Headache _____
- Seizures _____
- Dizziness _____
- Numbness _____

Allergic:

- Food Allergy _____
- Medication Allergy _____



8 Month Questionnaire

7 months 0 days
through 8 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:

Notes:

- 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 _____.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. If you call to 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"/>	___
2. 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"/>	___
3. 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"/>	___
4. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby respond to the tone of your voice and stop his activity at least briefly when you say "no-no" to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___





COMMUNICATION TOTAL _____

GROSS MOTOR


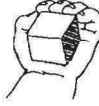


	YES	SOMETIMES	NOT YET	
1. When you put your baby on the floor, does she lean on her hands while sitting? (If she already sits up straight without leaning on her hands, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



GROSS MOTOR (continued)

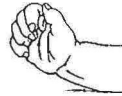
		YES	SOMETIMES	NOT YET	
3. Does your baby get into a crawling position by getting up on her hands and knees?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. If you hold both hands just to balance your baby, does he support his own weight while standing?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. When sitting on the floor, does your baby sit up straight for several minutes without using her hands for support?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
6. When you stand your baby next to furniture or the crib rail, does he hold on without leaning his chest against the furniture for support?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL					—
<i>*If Gross Motor Item 5 is marked "yes" or "sometimes," mark Gross Motor Item 1 "yes."</i>					

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1. Does your baby reach for a crumb or Cheerio and touch it with her finger or hand? (If she already picks up a small object, mark "yes" for this item.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby pick up a small toy, holding it in the center of his hand with his fingers around it?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. Does your baby try to pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion, even if she isn't able to pick it up? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. Does your baby pick up a small toy with only one hand?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—

FINE MOTOR (continued)

5. Does your baby *successfully* pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion? (If he already picks up a crumb or Cheerio, mark "yes" for this item.)



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

6. Does your baby pick up a small toy with the *tips* of her thumb and fingers? (You should see a space between the toy and her palm.)



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

*If Fine Motor Item 6 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."

PROBLEM SOLVING

1. Does your baby pick up a toy and put it in his mouth?



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

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

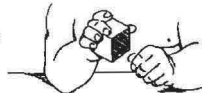
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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3. Does your baby play by banging a toy up and down on the floor or table?



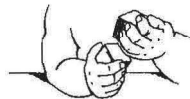
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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4. Does your baby pass a toy back and forth from one hand to the other?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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5. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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6. When holding a toy in his hand, does your baby bang it against another toy on the table?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
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PROBLEM SOLVING TOTAL _____

PERSONAL-SOCIAL

YES SOMETIMES NOT YET

1. When lying on her back, does your baby play by grabbing her foot?



 —

2. When in front of a large mirror, does your baby reach out to pat the mirror?



 —

3. Does your baby try to get a toy that is out of reach? (He may roll, pivot on his tummy, or crawl to get it.)

 —

4. While your baby is on her back, does she put her foot in her mouth?



 —

5. Does your baby drink water, juice, or formula from a cup while you hold it?

 —

6. Does your baby feed himself a cracker or a cookie?

 —

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

OVERALL (continued)

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