Southern Pediatric Clinic, LLC
Charlene C. Blache, M.D.
Pediatrics and Adolescent Medicine

406-M Northside Drive
Valdosta, GA 31602
Ph. 229 • 241 • 0059
Fax 229 • 241 • 2088

PATIENT

Last Name	First Name	MI	Date of Birth

PARENT/GUARDIAN

Last Name	First Name	MI

Patient Eligibility Screening Record

Vaccines for Children Program

Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. **While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).**

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of $21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child…		
(A) is enrolled in Medicaid (Peach**State**, WellCare, AmeriGroup, CareSource or SSI Medicaid).	◯	OR
(B) is American Indian or Alaskan Native.	◯	OR
(C) does not have health insurance.	◯	OR
(D) has health insurance that does not pay for vaccines.	◯	OR
(E) is enrolled in PeachCare (Peach**Care** will be listed as Managed Care Provider).	◯	OR
(F) has health insurance that pays for vaccines.	◯	

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Parent/Guardian Name (print) Signature Date

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Date

Child's Name

Date of Birth

PHQ-2

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless.	◯	◯	◯	◯

STOP HERE if you ANSWERED "not at all" to the above 2 questions!

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
3. Trouble falling or staying asleep, or sleeping too much.	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating.	◯	◯	◯	◯
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television.	◯	◯	◯	◯
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9. Thoughts that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

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? (Circle one)

Not difficult at all	Somewhat difficult	Very difficult	Extrememly difficult

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
6 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Maternal Depression screening and Oral Health Risk Assessment are also part of this visit.** Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your baby's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your baby's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING BABY

Do you have specific concerns about your baby's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your baby is able to do.

- ☐ Pat or smile at his reflection.
- ☐ Look when you call her name.
- ☐ Babble.
- ☐ Roll over from his back to his tummy.
- ☐ Sit briefly without support.
- ☐ Make sounds such as "ga," "ma," and "ba."
- ☐ Pass a toy from one hand to another.
- ☐ Rake small objects with 4 fingers.
- ☐ Bang small objects on a surface.

PATIENT NAME: _____ DATE: _____

Please print.

6 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your baby hears?	O No	O Yes	O Unsure
Lead	Does your baby live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your baby's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your baby or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your baby infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure
	Do your baby's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your baby's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you have the things you need to take care of the baby, such as a crib, a car safety seat, and diapers?	O Yes	O No
Does your home have enough heat, hot water, electricity, and working appliances?	O Yes	O No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Family Relationships and Support		
Do you have people you can go to when you need help with your family?	O Yes	O No
Do you have child care or a reliable person to care for your baby?	O Yes	O No

CARING FOR YOUR BABY

Your Baby's Development		
Is your baby learning new things?	O Yes	O No
Is your baby adapting to new situations, people, and places?	O Yes	O No
Does your baby have ways to tell you what he wants and needs?	O Yes	O No
Does your baby respond when you look at books together?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?	O No	O Yes
Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day?_____ hours	O No	O Yes
Does your baby have a regular daily schedule for feeding, napping, playing, and sleeping?	O Yes	O No
Is your baby learning to go to sleep by himself?	O Yes	O No
Can your baby calm herself?	O Yes	O No
Do you have ways to help your baby calm himself if he cannot do it himself?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

6 MONTH VISIT

HEALTHY TEETH

Do you give your baby a bottle in her crib?	O No	O Yes

FEEDING YOUR BABY

General Information			
What are you feeding your baby? Check all that apply: _____ Breast milk _____ Formula _____ Both			
Are you feeding your baby any drinks or foods besides breast milk or formula? Check all that apply: ____ Water ____ Juice ____ Cereal ____ Meats ____ Fruits ____ Vegetables ____ Other foods			
Does your baby let you know when he likes or dislikes new foods that you have introduced?		O Yes	O No
Do you wash vegetables and fruits before serving them to your baby and family?		O Yes	O No
If you are breastfeeding, answer these questions.			
Are you planning on continuing?	O NA	O Yes	O No
Do you have questions about pumping and storing your breast milk?		O No	O Yes
Are you still giving your baby vitamin D drops and iron drops?		O Yes	O No
If you are formula feeding, or providing formula supplementation, answer these questions.			
Are you using iron-fortified formula?		O Yes	O No
Do you have any questions or concerns about the formula, such as how much it costs or how to prepare it?		O No	O Yes

SAFETY

General Information		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	O Yes	O No
Are you having any problems with your car safety seat?	O No	O Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	O Yes	O No
Do you have barriers around space heaters, woodstoves, and kerosene heaters?	O Yes	O No
Do you put a hat on your baby and apply sunscreen on her when you go outside?	O Yes	O No
Do you keep household cleaners, chemicals, and medicines locked up and out of your baby's sight and reach?	O Yes	O No
Do you always stay within arm's reach of your baby when he is in the bath?	O Yes	O No
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O No
Safe Sleep		
Do you continue to place your baby onto her back for sleep?	O Yes	O No
Does your baby sleep in a crib?	O Yes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®