

CHILD'S NAME (LAST, FIRST, MI) \_\_\_\_\_

SPONSOR'S SSN# LAST 4 (last name if different than child) \_\_\_\_\_

CHILD'S BIRTHDATE \_\_\_\_\_

#### 4 MONTH SCREENING QUESTIONNAIRE

<b>Anemia screening</b>	
~Was your child born prior to 35 weeks gestation?	( ) yes ( ) no ( ) don't know
~Was your child < 2500 gms ( <5 lbs 8 ozs) at birth?	( ) yes ( ) no ( ) don't know
~Was or is your child on low iron or no iron formula?	( ) yes ( ) no ( ) don't know
<b>Hearing Screening</b>	
~ Do you have any concerns about your child's hearing?	( ) yes ( ) no ( ) don't know
<b>Vision Screening</b>	
~Do you have any concerns about your child's vision?	( ) yes ( ) no ( ) don't know

Please also complete the separate Post Partum Depression Screen.