SOUTHERN OREGON
PEDIATRICS

Name_____ **Date**_____

2-4 week old screening

	Yes	No	Unsure
1. Do you have concerns about how your child sees?			
2. Has a family member or contact had tuberculosis or a positive tuberculin skin test?			
3. 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)?			
4. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?			
5. Have there been any major changes in your family lately?			
6. Is your child ever around tobacco smoke?			
7. Do you feel you have difficulties providing enough food to feed your family?			

Development: Does your baby do the following?	**Yes**	**No**	**Unsure**
1. Raises his/her head slightly when prone?			
2. Fixes on faces or objects and follows movements with his/her eyes?			

Over the past 2 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				