New Mexico
Early Childhood
Education & Care Department

Maternal-Child Health Form – Child 0-5 Months

Client Name _____ Date _____

Did you begin breastfeeding your baby (select one)?

☐ Yes ☐ No ☐ N/A

Duration child receives breastmilk (select one)

- ☐ NA (older child)
- ☐ Less than 3 months (when stopped)
- ☐ 3-5 months (when stopped)
- ☐ More than 6 months (when stopped)
- ☐ In progress/ still breastfeeding
- ☐ Unknown

What is the child's usual source of medical care / location of regular checkups (select one)?

- ☐ Doctor's/nurse practitioner's office
- ☐ Hospital or ER
- ☐ Hospital outpatient
- ☐ Federally Qualified Health Center
- ☐ Retail store or minute clinic
- ☐ Other
- ☐ None

Well child visit - 5 days (select one)

- ☐ Received
- ☐ Missed
- ☐ Unknown

Well child visit – 1 Month (select one)

- ☐ Received
- ☐ Missed
- ☐ Unknown

Well child visit – 2 Month (select one)

- ☐ Received
- ☐ Missed
- ☐ Unknown

Well child visit – 4 Month (select one)

- ☐ Received
- ☐ Missed
- ☐ Unknown

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Immunizations: Has your child had all recommended shots (select one)?

- ☐ Yes
- ☐ No
- ☐ Medical Exemptions
- ☐ Religious Exemptions
- ☐ Personal or Philosophical Exemptions

Has child been in a hospital emergency room in the past 12 months? # of times: (select one)

☐ None ☐ 1x ☐ 2x ☐ 3x or more

If yes, what are the reasons for ER visit?

- ☐ Injury from accident
- ☐ Reported child abuse or neglect
- ☐ Use ER for emergency medical care only
- ☐ Use ER for regular medical care
- ☐ Poison

Does your child have a usual source of dental care?

☐ Yes ☐ No ☐ N/A

Child sleeps in bed with parent, another caregiver or another child (select one)

☐ Always ☐ Sometimes ☐ Never

Child is placed on his/her back when they go to sleep (select one)

☐ Always ☐ Sometimes ☐ Never

There is soft bedding in the area where the child sleeps (select one)

☐ Always ☐ Sometimes ☐ Never

At least one person uses tobacco products in the home (select one)

☐ Always ☐ Sometimes ☐ Never

Results of child newborn hearing screening?

☐ Pass ☐ Refer ☐ Did not receive ☐ Unknown

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If referred after newborn hearing screening was recommended follow-up received (select one)?

☐ Yes ☐ No ☐ Unknown

Child had a screening/exam by a hearing specialist in the last 12 months (select one)

☐ Yes ☐ No ☐ Unknown

Hearing screening/exam results (select one)

☐ Could not test ☐ Refer ☐ Pass ☐ Unknown

Child had a screening/exam by a vision specialist in the last 12 months (select one)

☐ Yes ☐ No ☐ Unknown

Vision screening/exam results (select one)

☐ Could not test ☐ Refer ☐ Pass ☐ Unknown

How many times per week do you or a family member read, tell stories or sing songs to your child (select one)?

☐ Daily
☐ 3-5 times per week
☐ 1-3 times per week
☐ Do not read or tell stories or sing songs