Questionnaire for screening U2/U3

Name ______________________ Date of birth ______________

Dear parents,

in ordert to better assess your child's development, please answer the following questions. This questionnaire is voluntary and subject to the legal requirement concerning confidential medical communication.

Thank you very much!
The team of the clinic

Question	Answer
Do you have a midwife at home?	☐ yes ☐ no
Who?	
Do you currently have support at home?	☐ yes ☐ no
Who?	
Is your child experiencing difficulties in drinking/breastfeeding or difficulties in swallowing?	☐ yes ☐ no
Does your child show any conspicuous screaming?	☐ yes ☐ no
Are you or your family at risk of congenital hip dysplasia or did you or a family member have to wear "stretch pants" as an infant?	☐ yes ☐ no
Do you or any family members have eye diseases? If so, which ones: ☐ Strabismus ☐ Visual impairment/low vision (Amblyopia) ☐ Children's clouding of the lens of the eye (cataract) ☐ hereditary eye diseases: ☐ other:	☐ yes ☐ no
Do you or your family have congenital hearing problems or ear abnormalities? If so, which ones:	☐ yes ☐ no
Do you or your family have a weak immune system (immune defects)? If so, which ones:	☐ yes ☐ no
Do you or any family members have any of the following conditions: ☐ Allergies ☐ Asthma ☐ Neurodermatitis	☐ yes ☐ no

Has had your child serious illnesses, surgeries or other abnormalities since the last examination? ☐ yes ☐ no

If so, which ones:

Are you worried or do you have any issues at the moment? ☐ yes ☐ no

If so, specify:

Filled out by: ☐ mother ☐ father other:

Date, Signature: