Instructions: Assessment of the infant at baseline should include detailed review of the infant's health, anthropometry, and feeding history. This detailed guide is intended to be reviewed during the screening visit. Anthropometry measurements should be tracked using the appropriate growth chart per SSP section 7. If the infant has any gradable conditions, or if determined relevant by the clinician, document on the **Baseline Medical History Log CRF**. Add any medications the participant is currently taking to the **Concomitant Medications Log CRF**.

General Infant Medical/Medication History

- Does the infant have any medical or health problems?
- Was the infant born at a health facility, home, or elsewhere?
- Is the infant currently taking any medications?
- Has the infant ever been hospitalized for any reason other than their birth?
- Did your infant have to stay in an intensive care unit after birth?
- Was infant discharged at the same time as mother?
- How much did the infant weigh at birth? *(note: if <2000 grams, infant is not eligible for enrollment)*
- Does the infant show any clinical evidence of stunting or illness? *(note: if yes, infant may be ineligible per investigator discretion)*
- Has the infant ever had surgery?
- Has the infant ever been seen for emergency care?

Newborn Medical History

After delivery, did the infant have any medical problems involving the following:
(Note information may come through medical record review and/or discussion with mother.)

- Resuscitation at delivery (needed help to start breathing/crying)
- Apgar scores
- Preterm birth
- Did NOT get vitamin K and / or eye prophylaxis
- Hypoglycemia (low blood sugar)
- Hypothermia (low temperature)
- Sepsis screening lab work (to check for infection)
- Elevated bilirubin (jaundice)
- Circumcision
- Delayed passage of meconium
- Heart murmur
- Breathing problems (e.g. needed oxygen or help breathing, apnea/stopped breathing)
- Received antibiotics before discharge
- Received head ultrasound
- Received ophthalmologic (eye) exam
- Congenital anomalies identified
- Any other health issues

Body System Infant Medical History

Assess any significant medical problems involving the following organ/systems.

- Head, Eyes, Ears, Nose and Throat (HEENT)
- Gastrointestinal (GI), including diarrhea
- Genitals (undescended tests, hypospadias, male/female/intersex)
- Lymphatic
- Cardiovascular
- Liver
- Respiratory, including pneumonia
- Renal
- Musculoskeletal
- Missed vaccination(s)
- Malaria
- Skin
- Neurologic
- Endocrine/Metabolic
- Hematologic
- Cancer
- Allergies
- Weight loss or problems with weight gain
- Surgery
- Seizures (fits)
- Fever
- Injury
- Any other health issues
-

Anthropometry

At **all infant physical exams**, measure and record the following on appropriate source documentation and growth chart*:

- Current weight
- Current length
- Current head circumference

**At the first visit only, also record any available measurements from existing medical records*

Baseline Feeding History

Discuss the following aspects of the infants feeding history

- Does the infant have any issues with breastfeeding (e.g., trouble sucking or latching) or any special needs or medical problems that might affect feeding?
- Does the mother have any issues with milk supply or other challenges (e.g., sore/cracked/bleeding nipples, clogged ducts, mastitis) or any medical problems preventing breastfeeding?
- Any other issues?

Note: Quantitative aspects of feeding history (e.g. frequency) should be captured through administration of the **Feeding Assessment CRF*