Well Baby Check: 2 month visit questionnaire

**Interval History:**
Has your baby had any major illnesses, ER or Urgent Care trips since your last appointment in the office?  No Yes

**Development:**
- Does your baby regard your face (starting to focus with his/her eyes)?  Yes No
- Does your baby respond to voices or sounds?  Yes No
- Do you have any concerns about how your baby sees or hears?  No Yes
- Does your baby lift his/her head 45˚ when lying on his/her tummy?  Yes No
- Does your baby turn his/her head when lying on his/her tummy?  Yes No
- Does your baby talk to you (“coo”)?  Yes No
- Does your baby smile?  Yes No
- Can your baby grasp objects and let go?  Yes No

**Staying Healthy/Safety/Dental Health/Tobacco Exposure:**
- Does your baby watch TV?  No Yes
- Does your home have a working smoke detector?  Yes No
- Have you turned your water temperature down to low-warm (less than 120 degrees)?  Yes No N/A
- Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?  Yes No
- Do you always put your baby to sleep on her/his back?  Yes No
- Do you always stay with your baby when she/he is in the bathtub?  Yes No
- Do you always place your baby in a rear-facing car seat in the back seat?  Yes No
- Is your car seat the right one for the age and size of your baby?  Yes No
- Does your baby spend time in a home where a gun is kept?  No Yes Skip
  - If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?  Yes No N/A
- Does your baby spend time with anyone who smokes?  No Yes

**Parental Support:**
During the past 2 weeks, how often have you been bothered by the following problems:
- Feeling down, depressed, irritable, or hopeless?
  - [Not at all]  [Several days]  [More than half the days]  [Nearly every day]
- Little interest or pleasure in doing things?
  - [Not at all]  [Several days]  [More than half the days]  [Nearly every day]
Sleep:
How many hours does your baby sleep at night? ______ hours; and naps throughout the day? ______ hours

Nutrition/Physical Activity:
For Breastfeeding: How many minutes of feeding per side? ______ minutes
For formula/bottle feeding: How many ounces per feeding? ______ oz
If you are giving formula, what brand are you using? ________________
How often does your baby feed? Every ______ hours
How many feedings in 24 hours? ______ feedings
Do you give your baby a bottle of anything other than formula or breast milk? No Yes
Do you have any concerns about your baby’s feeding? No Yes

Elimination:
Does your baby have regular bowel movements with a soft/loose consistency? Yes No

Please list any medications or supplements your baby is taking, including vitamin D: ________________________________

Who lives in the home with your baby? ________________________________

Who provides daytime care for your child? ________________________________

Please list any major family medical issues: ________________________________

Please list any known Allergies: ________________________________

Do you have any concerns about your child’s development, or any other concern you would like to discuss?

______________________________

Parent or Guardian Signature: ________________________________

Date: ________________________________

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<th>Referred</th>
<th>Anticipatory Guidance</th>
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<td></td>
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□ Patient Declined the SHA

PCP’s Signature: ________________________________
Print Name: ________________________________
Date: ________________________________

Ver.12-12-17