Well Child Check: 2 Month Visit

Your Child's Name: __________________________________________________

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you.

Can your child hold the head somewhat steady as you pick him/her up?  Yes  No  Unsure

Does your child hold an object briefly?  Yes  No  Unsure

Does your child follow you or objects with his/her eyes?  Yes  No  Unsure

Does your child look at objects?  Yes  No  Unsure

Does your child look at faces?  Yes  No  Unsure

Does your child smile?  Yes  No  Unsure

Does your child coo (make "ooh", "aah" sounds)?  Yes  No  Unsure

Does your baby drink breast milk or formula?  Breast milk  Formula  Both

If you are giving formula how many ounces does your child take in 24 hours? _________________________ oz.

Type of formula?
_________________________________________________________________________________________

Do you always place your infant to sleep on the back?  Yes  No  Unsure

Does the baby always sleep in a crib or bassinet?  Yes  No  Unsure

Do you have working smoke alarms in your home?  Yes  No  Unsure

Are there smokers in your home?  No  Yes  Unsure

Do you have any safety concerns in your home?  No  Yes  Unsure

If so, what are your concerns?
_________________________________________________________________________________________

Over the past two weeks has mom been feeling sad, anxious, hopeless or depressed often?  No  Yes  Unsure

Over the past two weeks, has mom felt very little or no interest or pleasure in doing things?  No  Yes  Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:
_________________________________________________________________________________________

Who provides daytime care for your child?

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

If so, please describe:
_________________________________________________________________________________________

_________________________________________________________________________________________