Well Child Check: Newborn/2 Week 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.

Does your child lift the head?  Yes  No  Unsure
Does your child move arms equally and legs equally?  Yes  No  Unsure
Does your child seem to look at faces, objects or lights?  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?  ____________________________________________________________________________

About how many wet diapers has your baby had in the last 24 hours? _________________________________
About how many times has your baby pooped in the last 24 hours? ________ What Color? ______________

Are you interested in seeing a lactation specialist?  Yes  No  Unsure
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

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

_________________________________________________________________________________________

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:

_________________________________________________________________________________________

_________________________________________________________________________________________