

Patient Name/Date of Birth: _____

Well Baby Check: 0-2 week visit questionnaire

Interval History:

Was your baby born full term (gestational age 37 weeks or more)?	Yes	No	
Were there any problems with the pregnancy or delivery?	No	Yes	
Has your baby had any illnesses, ER or Urgent Care visits since hospital discharge, or since last seen by us?	No	Yes	
Did your baby pass the hearing test done in the hospital?	Yes	No	Unsure
Did your baby have a Newborn Screen done in the hospital? (a test where blood is taken from the heel)	Yes	No	Unsure

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	
Does your baby move both arms and legs equally?	Yes	No	
Do you have any concerns about how your baby sees or hears?	No	Yes	

Staying Healthy/Safety/Dental Health/Tobacco Exposure:

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 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 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]

Nutrition/Physical Activity:

What was your baby's birth weight? _____ lbs _____ oz

For Breastfeeding: How many minutes of feeding per side? _____ minutes

Patient Name/Date of Birth: _____

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/weight? No Yes Skip

Elimination:

Does your baby have at least 6-8 wet diapers in 24 hours? Yes No

Does your baby have a strong urine stream? Yes No Unsure

Does your baby have soft, yellow bowel movements? Yes No

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

 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 with your provider?

Signature: _____ Date: _____

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 2px solid black; padding: 5px; display: inline-block;"> <input type="checkbox"/> Patient Declined the SHA </div>
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature	Print Name:			Date:	