



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]



Medical Record Number

Patient Name

Questionnaire • Well Baby Check 0-2 Weeks

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Patient Label

Nutrition/Physical Activity:

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

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/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?

Parent or Guardian 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"/>	<input type="checkbox"/> Patient Declined the SHA
<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:	