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 ☐

Patient Name:

Date of Birth:

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: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date: