UW Medicine
UW NEIGHBORHOOD CLINICS

Two Month Old Well Child Visit

Baby's Name _____ Baby's Age _____ Date _____

Person completing the form _____ Relationship to the patient _____

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (Yes) (No)

Nutrition:	Yes	No
Is your baby feeding well?	( )	( )
Is your baby breast fed? If yes, how often?	( )	( )
Are you giving vitamins?	( )	( )
Are you offering anything else to your baby to eat or drink?	( )	( )
Is your baby formula fed?	( )	( )
If yes, what formula?		
If yes, how many ounces per feeding?		
If yes, how often?		

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:	Yes	No
Does your child sleep only on his/her back?	( )	( )
Does your child sleep in his/her own crib?	( )	( )
Does your child always ride in a car seat, in the back seat, facing backwards?	( )	( )
Do you, anyone who cares for your child, or anyone in your home smoke?	( )	( )

Behavioral/Mental Health:		
Does your child cry more than you expected?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
If yes, do you need assistance finding a daycare?	( )	( )

Developmental Surveillance:	Yes	No
Social/Emotional		
If upset, able to self soothe?	( )	( )
Looks at you?	( )	( )

Communicative		
Coos?	( )	( )
Smiles?	( )	( )

Cognitive		
Follows your face with her/his eyes?	( )	( )

Physical Development		
Lifts head when on tummy?	( )	( )
Moves both arms and legs equally?	( )	( )