UW Medicine
PRIMARY CARE

2-4-Week-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 breastfed?	( )	( )
• If yes, how often? _____		
Is your baby formula fed? If yes:	( )	( )
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		
Are you giving your baby vitamins?	( )	( )
Are you offering anything else to your baby to eat or drink?	( )	( )

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)?	( )	( )
If you have other children, are they having a hard time adjusting to the new baby?	( )	( )

Preventative Health/Risk Factors:	**Yes**	**No**
Does your child sleep only in his/her own bassinet or 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:	**Yes**	**No**
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 to find a suitable program?	( )	( )

Developmental Surveillance:	**Yes**	**No**
Social/Emotional: If upset, able to calm?	( )	( )
Communicative: Recognizes your voice?	( )	( )
Communicative: Starting to smile?	( )	( )
Cognitive: Follows your face with his/her eyes?	( )	( )
Physical Development: Lifts head when on tummy?	( )	( )