

2-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?	<input type="checkbox"/>	<input type="checkbox"/>
Is your baby breastfed?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, how often? _____		
Is your baby formula fed? If yes:	<input type="checkbox"/>	<input type="checkbox"/>
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		
Are you giving your baby vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
Are you offering anything else to your baby to eat or drink?	<input type="checkbox"/>	<input type="checkbox"/>

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

Preventative Health/Risk Factors:	Yes	No
Does your child sleep only on his/her back?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep in his/her own bassinet or crib?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child always ride in a car seat, in the back seat, facing backwards?	<input type="checkbox"/>	<input type="checkbox"/>
Do you, anyone who cares for your child, or anyone in your home smoke?	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral/Mental Health:	Yes	No
Does your child cry more than you expected?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about how your child is learning, developing and behaving?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in enrolling your child in daycare?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, do you need assistance to find a suitable program?	<input type="checkbox"/>	<input type="checkbox"/>

Developmental Surveillance:	Yes	No
Physical Development: Lifts head when on tummy?	<input type="checkbox"/>	<input type="checkbox"/>
Physical Development: Moves both arms and legs equally?	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive: Follows your face with his/her eyes?	<input type="checkbox"/>	<input type="checkbox"/>
Communicative: Coos?	<input type="checkbox"/>	<input type="checkbox"/>
Communicative: Smiles?	<input type="checkbox"/>	<input type="checkbox"/>
Social/Emotional: If upset, able to self-soothe?	<input type="checkbox"/>	<input type="checkbox"/>
Social/Emotional: Looks at you?	<input type="checkbox"/>	<input type="checkbox"/>

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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