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?	☐	☐
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)?	☐	☐

Preventative Health/Risk Factors:	**Yes**	**No**
Does your child sleep only on his/her back?	☐	☐
Does your child sleep 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**
Physical Development: Lifts head when on tummy?	☐	☐
Physical Development: Moves both arms and legs equally?	☐	☐
Cognitive: Follows your face with his/her eyes?	☐	☐
Communicative: Coos?	☐	☐
Communicative: Smiles?	☐	☐
Social/Emotional: If upset, able to self-soothe?	☐	☐
Social/Emotional: Looks at you?	☐	☐

PLACE PATIENT LABEL HERE