



# Health Maintenance Questionnaire

# 2 MONTHS

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_\_

PARENTS \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION	PHYSICIAN'S COMMENTS
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**HISTORY**

Describe any recent injuries or illnesses: \_\_\_\_\_

List medications taken routinely:  none

Note any new stresses in the family: \_\_\_\_\_

Are siblings adjusting to baby OK?  
 No siblings  Yes  No

Is your baby in day care?  No  
 Home based  Center based  Nanny  Other:  
How many kids? \_\_\_\_\_

Are there smokers in your baby's home or daycare?  
 No  outside  other room

**PHYSICIAN'S COMMENTS**

Observe temperament / interactions

Call with rectal temp >100.5°

Discussed risks of 2<sup>nd</sup> hand smoke.

**NUTRITION**

**FORMULA FEEDING:**  
How many ounces in 24 hrs? \_\_\_\_\_ What formula? \_\_\_\_\_

**BREAST FEEDING:**  
How many times does baby nurse in 24 hours?  
How many minutes is each feeding?

**Y N**

Is baby fed on demand?  
  Have you given supplemental formula?  
  Are you pumping breast milk?

How many of each per day: spit ups \_\_\_\_\_ wets \_\_\_\_\_  
How often does baby pass stool? \_\_\_\_\_

**Shaded items are new for the 2 mo check-up.**

**BREAST FEEDING RECOMMENDATIONS**

Expect at least one feeding at night.  
 Should gain 4-7oz per week.  
 8-12 feedings in 24 hrs is typical.  
 Feeding duration may shorten.  
 Nurse in a quiet place to lessen distractions.  
 Don't restrict feedings / Feed on demand.  
 Don't overuse the pacifier. Is baby hungry?  
 Back to work? Pump and freeze milk properly.  
 If needed, introduce bottle or cup.  
 Delay solids until discussed with your doctor.  
 Mom should not diet. Drink to thirst.  
 Vitamins usually not necessary.

**STOOLING EXPECTATIONS**

**BREAST FED:** Stools may occur several times per day or only once per week. This is normal if it is soft.  
 **FORMULA FED:** Stool frequency is variable, but should not be hard balls.

PHYSICAL EXAM	LAB	IMMUNIZATIONS
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Ht \_\_\_\_\_ Wt \_\_\_\_\_ HC \_\_\_\_\_ VS: \_\_\_\_\_

Check if normal:

<input type="checkbox"/> Head/Fontanel	<input type="checkbox"/> Nose	<input type="checkbox"/> Lungs	<input type="checkbox"/> Back
<input type="checkbox"/> Eyes/Red reflexes	<input type="checkbox"/> Mouth	<input type="checkbox"/> Heart	<input type="checkbox"/> Hips
<input type="checkbox"/> Ears	<input type="checkbox"/> Throat	<input type="checkbox"/> Femoral pulses	<input type="checkbox"/> Extremities
	<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin
	<input type="checkbox"/> Chest	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Neurologic

Given at Health Department

<input type="checkbox"/> DTaP	<input type="checkbox"/> HepB
<input type="checkbox"/> IPV	<input type="checkbox"/> Hib
<input type="checkbox"/> Comvax	Other: _____
<input type="checkbox"/> Prevnar	

**ASSESSMENT**

1.  NORMAL GROWTH and DEVELOPMENT. More information on other side.

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**PLAN**

1.  Follow up at 4 months for Health Review.  Anticipatory handouts given.

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DEVELOPMENT AND BEHAVIOR	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's development or behavior?	
<b>Y N</b> <input type="checkbox"/> Does baby respond to sounds by becoming alert and quiet? <input type="checkbox"/> Does s/he look at your face and follow you with his/her eyes past midline?	
<b>M O T O R</b>	<b>Y N</b> <input type="checkbox"/> Does baby hold his/her head in the midline when held in an upright position? <input type="checkbox"/> Does baby lift his/her chest off the floor during "tummy time?" <input type="checkbox"/> Will baby grasp a finger or rattle placed in his/her hand?
<b>L A N G U A G E</b>	<b>Y N</b> <input type="checkbox"/> Do you talk, read and sing to baby? <input type="checkbox"/> Does s/he respond to your voice by cooing?
<b>S O C I A L</b>	<b>Y N</b> <input type="checkbox"/> Does s/he enjoy looking at a mobile and non-breakable mirror? <input type="checkbox"/> Does baby respond by smiling? <input type="checkbox"/> Can s/he be consoled from crying most of the time? (Colic usually goes away around 3 months of age.)
<b>S L E E P</b>	How many hours does baby sleep at a time? _____ <b>Y N</b> <input type="checkbox"/> Have you established a bedtime routine? <input type="checkbox"/> Do you put baby down when drowsy to teach self-quieting? <input type="checkbox"/> Do you put baby down on his/her back? <input type="checkbox"/> Do you avoid bulky bedding in the crib? <input type="checkbox"/> Do you alternate baby's head position to prevent flattening of the skull?  Where does baby sleep?

SAFETY AWARENESS
Please review the shaded items, which are new for the 2 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/>
<b>Y N</b> <input type="checkbox"/> Do you avoid drinking hot liquids while holding your baby? <input type="checkbox"/> Do you limit sun exposure? <input type="checkbox"/> Do you avoid putting baby in the car seat / bouncy seat set in high places? <input type="checkbox"/> Do you avoid the use of baby walkers?  <input type="checkbox"/> Is baby's car seat rear facing in the back seat? (Do this until 1 yr old AND 20 lbs) <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> Do you monitor baby closely around young siblings or pets? <input type="checkbox"/> Do you avoid putting necklaces or pacifiers on strings around baby's neck? <input type="checkbox"/> Are you aware that shaking your baby could cause permanent brain damage?

Who answered the above questions? \_\_\_\_\_ Thank you for helping us help you and your child!!  
**Please put this paper in the box hanging outside the door so that we know you are finished!**