



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 2nd 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

Yes No Are you concerned about your child's development or behavior?

Y N

- Does baby respond to sounds by becoming alert and quiet?
 Does s/he look at your face and follow you with his/her eyes past midline?

M
O
T
O
R

Y N

- Does baby hold his/her head in the midline when held in an upright position?
 Does baby lift his/her chest off the floor during "tummy time?"
 Will baby grasp a finger or rattle placed in his/her hand?

L A N G U A G E

Y N

- Do you talk, read and sing to baby?
 Does s/he respond to your voice by cooing?

S
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C
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A
L

Y N

- Does s/he enjoy looking at a mobile and non-breakable mirror?
 Does baby respond by smiling?
 Can s/he be consoled from crying most of the time?
 (Colic usually goes away around 3 months of age.)

S
L
E
E
P

How many hours does baby sleep at a time? _____

Y N

- Have you established a bedtime routine?
 Do you put baby down when drowsy to teach self-quieting?
 Do you put baby down on his/her back?
 Do you avoid bulky bedding in the crib?
 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.

Y N

- Do you avoid drinking hot liquids while holding your baby?
 Do you limit sun exposure?
 Do you avoid putting baby in the car seat / bouncy seat set in high places?
 Do you avoid the use of baby walkers?
- Is baby's car seat rear facing in the back seat? (Do this until 1 yr old AND 20 lbs)
 Is the water temperature in your house less than 120 degrees?
 Do you have a fire escape plan?
 Do you check your smoke detectors regularly?
 Do you monitor baby closely around young siblings or pets?
 Do you avoid putting necklaces or pacifiers on strings around baby's neck?
 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!