Woodinville Pediatrics 2 Month Questionnaire

Patient Name:_____ Date:_____

Parental concerns this visit: _____
_____

Current Medications: _____
Current Allergies: _____

Family
Concerns about maternal depression ____yes ____no
Reactions of sibling to new child _____
Parents working outside home ____mother ____father
Child Care ____yes ____no Type_____
Changes since last visit _____

Diet
Milk _____
Type _____
Amt/Time per feeding _____
Frequency _____
Source of water _____ Vitamin D ____yes ____no

Bowel/Bladder
Stool Concerns ____yes ____no
Stool Consistency ____hard ____soft
Urination Concerns ____yes ____no

Sleep
Back sleeping ____yes ____no
Location ____co-sleep ____crib ____co-sleep & crib
Duration ____ < 3 hrs ____ 3-6 hrs ____ > 6 hrs

Tobacco Exposure ____yes ____no

Behavior Concerns ____yes ____no

Development
Social Emotional: ___Smiles ___Looks at parents ___Self-comfort
Communication: ___ Coos ___ Different cries for different needs
Cognitive: ___ Indicates boredom when no activity change
Physical: ___ Lifts head and begins to push up when prone
___ Holds head erect for short periods (when held up right)
___ Diminished newborn reflexes
___ Symmentrical movement

Additional comments: _____

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