



Office Use Only

- VFC: MDD/DKC
- Native
- NO Insurance
- Not Eligible

INSURANCE Notes

Office Use Only

WT: _____ kg _____ lb
 Length: _____
 OFC: _____

2 Month Well Baby Questionnaire

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.

Child's Name: _____

Birth Date: _____

Do you have any concerns about your baby today? _____

Is your baby on any medicine? Yes / No. Which ones/dose? _____

Any allergies to medicine, latex, etc? Yes / No. Which ones? _____

Has your baby had any surgeries? Yes / No. If yes, describe: _____

Has your child been hospitalized overnight? Yes / No. Is yes, why: _____

Health

Is your baby exhibiting any of the following symptoms?

- | | | | |
|------------------------|-----------------------------------|------------|----------------------------------|
| Ear Pain / Ear Pulling | Yes / No. If yes, how long? _____ | Fever | Yes / No. If yes, how long _____ |
| Ear Drainage | Yes / No. If yes, how long? _____ | Swelling | Yes / No. If yes, how long _____ |
| Eye Drainage | Yes / No. If yes, how long? _____ | Cough | Yes / No. If yes, how long _____ |
| Decreased Appetite | Yes / No. If yes, how long? _____ | Vomiting | Yes / No. If yes, how long _____ |
| Constipation / Gas | Yes / No. If yes, how long? _____ | Diarrhea | Yes / No. If yes, how long _____ |
| Urinary Symptoms | Yes / No. If yes, how long? _____ | Rash | Yes / No. If yes, how long _____ |
| Sleep Problems | Yes / No. If yes, how long? _____ | Joint Pain | Yes / No. If yes, how long _____ |

Nutrition

Breast Feeding Yes / No	Formula Feeding Yes / No
How often & how long? _____	Which formula? _____
Is mom on any medication or vitamin supplements? Yes / No. Which ones? _____	How many ounces & how often? _____

Is your baby on vitamins? Yes / No. If yes, which brand? _____

Circle your baby's water supply source: City Bottled Well.

Social

Any changes in your baby's environment? _____

Who lives in the household with you? _____

Who is the primary caretaker? _____ Is Mom working? Yes / No. Full time / Part Time

Does anyone in the family smoke? Yes / No. If yes, who? _____

Is your baby in daycare? Yes / No. If yes, where? _____

Any pets? Yes / No. If yes, which kind? _____

Any food allergies in your family? Yes / No. If yes, who and to what? _____

Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____

Development

Do you have any developmental concerns about your baby's development? _____

- | | | | |
|--------------------------------------------------------|-----------|----------------------------------|-----------|
| Can your baby: Smile responsively? | Yes / No. | Hold head erect when sitting up? | Yes / No. |
| Respond to sounds? | Yes / No. | Lift head when on their tummy? | Yes / No. |
| Coo? | Yes / No. | | |
| Turn their head to follow you if you move to the side? | Yes / No. | | |

Sleep and Elimination

How many hours does your baby sleep straight at night? _____

How many naps does your baby take each day? _____ Duration? _____

How many wet diapers per day? _____ How many stools? _____ Does your baby have a good urine stream? Yes / No.

This form completed by: _____ Relationship to Child: _____