



2 Week Well Baby Questionnaire

Office Use Only

VFC: [] MDD/DKC
 [] Native
 [] NO Insurance
 [] Not Eligible

INSURANCE Notes

Office Use Only

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

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. If your child requires significant medical intervention 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: _____

Birth History/Delivery

Full term or premature (please circle) If premature, how many weeks early. _____ Vaginal or Cesarean (please circle)

Head first or breech delivery (please circle) Any complications? _____

Forceps or vacuum used (please circle) Birth weight _____ Discharge weight _____

Health

Is your baby exhibiting any of the following symptoms?

Decreased Appetite Yes / No. If yes, how long? _____ | Fever Yes / No. If yes, how long _____

Ear Drainage Yes / No. If yes, how long? _____ | Rash Yes / No. If yes, how long _____

Eye Drainage Yes / No. If yes, how long? _____ | Constipation / Gas 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? _____

Does your baby:

Respond to loud noises? Yes / No. | Briefly lift head when lying on tummy? Yes / No. | Move all extremities equally? 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: _____