Office Use Only

VFC: [ ] V02 -- MDD
[ ] V03 – No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

2 Week 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. *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.*

Office Use Only

WT: _____

HT: _____

OFC:_____

Temp: _____

Resp: _____

Pulse: _____

Oxygen: _____

Child's Name: _____Birth Date: _____

Do you have any concerns about your baby today? _____

Is your baby on any medicine/ vitamins? 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 _____Length_____

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? _____ Alternating sides? Yes / No Pumping and feeding expressed milk (bottle)? Yes / No Is mom on any medication or vitamin supplements? Yes / No. Which ones? _____	Which formula? _____ How many ounces & how often? _____ Circle your baby's water supply source: City Bottled Well.

Do you have any questions or concerns you would like to discuss with the Certified Breast Feeding Specialist? 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.

Social:

Is this child yours by: __ birth __ adoption __ marriage (stepchild) other _____

Any changes in your baby's environment? (new home, pets, daycare, etc.)_____

Who lives in the household with the baby (please list for all households if more than one)? **Name, Relationship, Age**

_____

Who is the primary caretaker in the home? _____

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? _____

Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _____

Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _____

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

Do you have any pets in your home? Yes / No. Which kind/how many? _____

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.

This form completed by: _____ Relationship to Child: _____ Today's Date_____